(10)

No. 04-1506
Title: Arkansas Department of Health and Human Services, et al., Petitioners
v.
Heidi Ahlborn
Docketed: May 11, 2005
Lower Ct: United States Court of Appeals for the Eighth Circuit
Case Nos.: (03-3377)
Decision Date: February 9, 2005

Date	Proceedings and Orders
May 9 2005	Petition for a writ of certiorari filed. (Response due June 10, 2005)
May 23 2005	Waiver of right of respondent Heidi Ahlborn to respond filed.
Jun 7 2005	DISTRIBUTED for Conference of June 23, 2005.
Jun 20 2005	Response Requested . (Due July 20, 2005)
Jul 13 2005	Order extending time to file response to petition to and including August 19, 2005.
Aug 17 2005	Brief of respondent Heidi Ahlborn in opposition filed.
Aug 31 2005	DISTRIBUTED for Conference of September 26, 2005.
Sep 27 2005	Petition GRANTED.
Oct 17 2005	Extension of time within which to file the joint appendix and petitioners' brief on the merits to and including November 23, 2005.
Nov 22 2005	Joint appendix filed.
Nov 22 2005	Brief of petitioners Arkansas Department of Human Services, et al. filed.
Nov 23 2005	Brief amicus curiae of United States filed.
Nov 23 2005	Brief amici curiae of Washington, et al. filed.
Nov 30 2005	SET FOR ARGUMENT on Monday, February 27, 2006.
Dec 7 2005	Extension of time within which to file respondent's brief on the merits to and including January 13, 2006.
Dec 9 2005	CIRCULATED.
Dec 12 2005	Motion of the Solicitor General for leave to participate in oral argument as amicus curiae and for divided argument filed.
Jan 12 2006	Brief of respondent Heidi Ahlborn filed. (Distributed)
Jan 13 2006	Brief amicus curiae of Association of Trial Lawyers of America filed. (Distributed)
Jan 17 2006	Record received from U.S.C.A. 8th Circuit. (1 envelope)
Jan 23 2006	Motion of the Solicitor General for leave to participate in oral argument as amicus curiae and for divided argument GRANTED.
Jan 25 2006	Record received from U.S.D.C. for Eastern District of Arkansas. (1 envelope)
Feb 7 2006	Reply of petitioners Arkansas Department of Human Services, et al. filed. (Distributed)
Feb 27 2006	Argued. For petitioners: Lori Feno, Assistant Attorney General, Little Rock, Ark.; and Patricia A. Millett, Assistant to the Solicitor General, Department of Justice, Washington, D.C. (for the United States, as amicus curiae.) For respondent: H. David Blair, Batesville, Ark.

Supreme Court, U.S.
FILED
041506 MAY 9 - 2005
OFFICE OF THE CLERK

No. _____

In The

Supreme Court of the United States

ARKANSAS DEPARTMENT OF HUMAN SERVICES, *et al.*,

Petitioners,

vs.

HEIDI AHLBORN,

Respondent.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Eighth Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTION PRESENTED

Whether federal Medicaid law, which requires that a medical assistance recipient assign to the state any right to payment from a third party who is liable for the recipient's medical expenses, and which also prohibits the placement of a pre-death lien upon a recipient's "property," entitles the state to full reimbursement from personal injury settlement proceeds of Medicaid benefits paid on the recipient's behalf, regardless of what portion of the settlement proceeds are designated as compensation for medical care?

PARTIES TO THE PROCEEDING

The parties to the proceeding are:

HEIDI AHLBORN, an individual;

ARKANSAS DEPARTMENT OF HUMAN SERVICES; KURT KNICKREHM, Director of the Arkansas Department of Human Services; WAYNE OLIVE, Director of Third Party Liability Unit, Arkansas Department of Human Services; ROY JEFFUS, Interim Director, Division of Medical Services, Arkansas Department of Human Services.

TABLE OF CONTENTS

	Page
QUESTION PRESENTED	i
PARTIES TO THE PROCEEDING	ii
TABLE OF CONTENTS	iii
TABLE OF AUTHORITIES	vi
CITATION OF OPINIONS ENTERED IN THE CASE	1
BASIS FOR SUPREME COURT JURISDICTION	1
STATUTES AND REGULATIONS INVOLVED IN THE CASE	1
STATEMENT OF THE CASE	4
Introduction	4
A. Federal Statutory And Regulatory Background	6
1. The Medicaid Program In General	6
2. Third Party Recovery And Assignment Provisions	8
3. The "Anti-Lien Provision"	9
B. Arkansas's Compliance With The Act's Recovery And Assignment Provisions	10
C. Procedural History	11
1. United States District Court For The Eastern District Of Arkansas	11
2. United States Court Of Appeals For The Eighth Circuit	14
ARGUMENT	16

TABLE OF CONTENTS – Continued

Page

A. Certiorari Is Appropriate Because A Substantial Conflict Exists Between *Ahlborn* And Decisions Of Several Other Courts 16

1. The *Ahlborn* Decision Conflicts With Decisions Of The Highest Courts Of Utah, Washington, And New York That Directly Addressed The Federal Anti-Lien Provision..... 17

2. The *Ahlborn* Decision Conflicts With Decisions Of The Second Circuit And The Supreme Court Of North Dakota That Addressed The States' Right To Full Reimbursement For Medical Expenses From Third-Party Settlements 20

3. The *Ahlborn* Decision Is Consistent With That Of The Supreme Court Of Minnesota 21

B. Certiorari Is Appropriate Because *Ahlborn* Conflicts With Adjudications And Interpretations Rendered By The United States Department Of Health And Human Services..... 22

1. HHS's Departmental Appeals Board Decisions, Which Are Entitled To Deference, Conflict With The *Ahlborn* Decision 24

2. HHS's Interpretation Of Medicaid Law, Which Is Entitled To Deference, Allows States To Place Liens On Settlements With Third Parties For The Full Amount That The Program Paid To The Recipient..... 25

TABLE OF CONTENTS – Continued

Page

C. Certiorari Is Appropriate Because This Case Involves An Important Question Of Federal Law That Has Not Been, But Should Be, Settled By This Court..... 26

1. This Case Presents A Question Of Significant National Importance..... 27

2. The *Ahlborn* Decision Misinterpreted Federal Medicaid Law, Thereby Minimizing A Key Purpose Of The Social Security Act 30

CONCLUSION..... 30

TABLE OF AUTHORITIES

Page

FEDERAL CASES

Atkins v. Rivera, 477 U.S. 154 (1986) 6

Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc., 467 U.S. 837 (1984) 15, 23

Erlenbaugh v. United States, 409 U.S. 239 (1972) 30

Harris v. McRae, 448 U.S. 297 (1980) 7

Schweiker v. Gray Panthers, 453 U.S. 34 (1981) 7

Sullivan v. County of Suffolk, 174 F.3d 282 (2nd Cir. 1999), *cert. denied*, 528 U.S. 950 (1999) 16, 20

United States v. Lorenzetti, 467 U.S. 167 (1984) 27

United States v. Mead Corp., 533 U.S. 218 (2001) 23

Wisconsin Dep't of Health and Family Services v. Blumer, 534 U.S. 473 (2002) 23, 24

Zinman v. Shalala, 67 F.3d 841 (9th Cir. 1995) 27

STATE CASES

Calvanese v. Calvanese, 710 N.E.2d 1079 (N.Y. 1999), *cert. denied*, 528 U.S. 928 (1999) 16, 19, 21

Cricchio v. Pennisi, 683 N.E.2d 301 (N.Y. 1997) 16, 18, 19, 20

Grey Bear v. North Dakota Dept. of Human Services, 651 N.W.2d 611 (N.D. 2002) 16, 21

Houghton v. Department of Health, 57 P.3d 1067 (2002), *cert. denied*, 538 U.S. 945 (2003) 16, 18

Martin v. City of Rochester, 642 N.W.2d 1 (Minn. 2002), *cert. denied*, 539 U.S. 957 (2003) 16, 21, 22

TABLE OF AUTHORITIES – Continued

Page

Padgett v. Toal, 81 S.E.2d 744 (Ga. Ct. App. 2003) 27

Wilson v. State, 10 P.3d 1061 (2000), *cert. denied*, 532 U.S. 1020 (2001) 16, 17, 21

DECISIONS OF THE DEPARTMENT OF APPEALS BOARD, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES

California Dep't of Health Services, DAB No. 1504, 1995 WL 66334 (Dep't of Health and Human Services January 5, 1995) 24

Washington State Dep't of Social & Health Services, DAB No. 1561, 1996 WL 157123 (Dep't of Health and Human Services February 7, 1996) 25

FEDERAL STATUTES

28 U.S.C. § 1254(1) 1

28 U.S.C. § 2101(c) 1

42 U.S.C. § 1382b 4, 7, 13

42 U.S.C. §§ 1396-1396v 6

42 U.S.C. § 1396a ..... *passim*

42 U.S.C. § 1396k ..... *passim*

42 U.S.C. § 1396p 3, 9, 10

STATE STATUTES

Alaska Stat. § 47.05-075(a) 28

Ark. Code Ann. § 20-76-201(1) 4, 10

Ark. Code Ann. § 20-77-301 *et seq* 4, 10

TABLE OF AUTHORITIES – Continued

Page

Arkansas Code Annotated § 20-77-307 ..... 3, 4, 10, 28
Cal. Welf. & Inst. Code § 14124.78 28
Mont. Code Ann. § 53-2-612(3)(a)(i) 28
62 Pa. Cons. Stat. § 1409(b)(11) 28

FEDERAL REGULATIONS

20 C.F.R. § 416.1201(a) 16
42 C.F.R. §§ 430.0-430.48 7
42 C.F.R. § 430.0 ..... 4, 7
42 C.F.R. § 430.35 ..... 4, 7
42 C.F.R. § 433.140(a)(1) 4, 7
42 C.F.R. § 447.302 4

RULES OF THE SUPREME COURT OF THE UNITED STATES

Rule 13.3 1

OTHER AUTHORITIES

HCFA letter entitled "Third Party Liability Relationship to Liens" (issued September 2, 1994) 26
HCFA letter entitled "State Third Party Liability (TPL) Subrogation Legislation" (issued June 1, 1998) 26
S. Rep. No. 99-146, at 312 (1985), *reprinted in* 1986 U.S.C.C.A.N. 42, 279 ..... 4, 7, 23

CITATION OF REPORTS OF OPINIONS ENTERED IN THE CASE

Heidi Ahlborn v. Arkansas Dep't of Human Services, et al., 397 F.3d 620 (8th Cir. February 9, 2005). App. 1.

Heidi Ahlborn v. Arkansas Dep't of Human Services, et al., 280 F.Supp.2d 881 (E.D. Ark. 2003). App. 16.

BASIS FOR SUPREME COURT JURISDICTION

The United States Court of Appeals for the Eighth Circuit entered its judgment on February 9, 2005. App. 1, 15. Petitioners Arkansas Department of Human Services, *et al.*, seek review of that judgment on a writ of certiorari. The present petition is timely filed pursuant to 28 U.S.C. § 2101(c) and Rule 13.3 of this Court.

This Court has jurisdiction under 28 U.S.C. § 1254(1) to review on a writ of certiorari the judgment of a federal court of appeals.

STATUTES AND REGULATIONS INVOLVED IN THE CASE

42 U.S.C. § 1396a

(a) Contents. A State plan for medical assistance must –

...

(25) provide –

(A) that the state ... administering such plan will take all reasonable measures to ascertain the legal liability of third parties ... to pay for care and services under the plan.

...

(B) that in any case where such a legal liability is found to exist after medical assistance has been made available on behalf of the individual and where the amount of reimbursement the State can reasonably expect to recover exceeds

the costs of such recovery, the State . . . will seek reimbursement for such assistance to the extent of such legal liability;

. . .

(H) that to the extent that payment has been made under the State plan for medical assistance in any case where a third party has a legal liability to make payment for such assistance, the State has in effect laws under which, to the extent that payment has been made under the State plan for medical assistance for health care items or services furnished to an individual, the State is considered to have acquired the rights of such individual to payment by any other party for such health care items or services;

42 U.S.C. § 1396k

(a) For the purpose of assisting in the collection of medical support payments and other payments for medical care owed to recipients of medical assistance under the State plan approved under this title [42 U.S.C. §§ 1396 et seq.], a State plan for medical assistance shall –

(1) provide that, as a condition of eligibility for medical assistance under the State plan to an individual who has the legal capacity to execute an assignment for himself, the individual is required –

(A) to assign the State any rights, of the individual or of any other person who is eligible for medical assistance under this subchapter and on whose behalf the individual has the legal authority to execute an assignment of such rights

to . . . payment for medical care from any third party.

. . .

(C) to cooperate with the State in identifying, and providing information to assist the State in pursuing, any third party who may be liable to pay for care and services available under the plan.

. . .

(b) Such part of any amount collected by the State under an assignment made under the provisions of this section shall be retained by the State as is necessary to reimburse it for medical assistance payments made on behalf of an individual with respect to whom such assignment was executed (with appropriate reimbursement of the Federal Government to the extent of its participation in the financing of such medical assistance), and the remainder of such amount collected shall be paid to such individual.

42 U.S.C. § 1396p

(a) Imposition of lien against property of an individual on account of medical assistance rendered to him under a State plan.

(1) No lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan.

Arkansas Code Annotated § 20-77-307

(a) As a condition of eligibility, every Medicaid applicant shall automatically assign his or her right to any settlement, judgment, or award which may be obtained against any third party to the Department of Human Services to the full extent of any amount

which may be paid by Medicaid for the benefits of the applicant.

(b) The application for Medicaid benefits shall, in itself, constitute an assignment by operation of law.

(c) The assignment shall be considered a statutory lien on any settlement, judgment, or award received by the recipient from a third party.

The following statutes and regulations are set forth in the appendix:

42 U.S.C. § 1382b(a), App. 32.

42 C.F.R. § 430.0, App. 36.

42 C.F.R. § 430.35, App. 36.

42 C.F.R. § 433.140(a)(1), App. 37.

42 C.F.R. § 447.302, App. 37.

Ark. Code Ann. § 20-76-201(1), App. 37.

Ark. Code Ann. §§ 20-77-301 through 20-77-307, App. 38.

S. Rep. No. 99-146 at 312 (1985), *reprinted in* 1986 U.S.C.C.A.N. 42, 312, App. 44.

STATEMENT OF THE CASE

Introduction

Heidi Ahlborn was involved in a motor vehicle accident in January of 1996. App. 2. As a result of the accident, she suffered severe injuries that required extensive medical care. *Id.* During her treatment, Ahlborn applied for and received medical benefits under the Arkansas Medicaid program, which is administered by the Arkansas Department of Human Services ("Department"). *Id.* In total, the Arkansas Medicaid program paid benefits to or on behalf of Ahlborn of at least $215,645.30, which fully compensated her health-care providers. *Id.*

As a condition of her eligibility for Medicaid benefits, Ahlborn had assigned to the Department her "right to any settlement, judgment, or award" that she might receive

from third parties liable for the medical costs resulting from her accident "to the full extent of any amount which may be paid by Medicaid." App. 4. This assignment was made pursuant to Arkansas law, which the State enacted in compliance with a mandate under federal Medicaid law that participating states have in effect such an assignment requirement. App. 8, 9.

Ahlborn filed a personal injury lawsuit against third parties who she alleged were liable for her injuries. R. 29-20, 27.[1] Ahlborn estimated that her damages from the accident totaled approximately $3,040,708.12, which included medical care, loss of earnings and work time, pain and suffering, and permanent impairment of ability to earn in the future. App. 2, 17. Despite inquiries from the Department and its intervention into the lawsuit, Ahlborn reached a compromise settlement of $550,000.00 for her claim without notifying the Department of the ongoing negotiations or involving it in the settlement decision. App. 2; R. 19, 21. The Department subsequently asserted a lien in the amount of $219,156.78 against the settlement proceeds, which represented the amount paid by the Arkansas Medicaid program to or on behalf of Ahlborn to cover her medical expenses resulting from the accident. App. 18 n. 2.

Ahlborn subsequently brought suit against the Department and several of its officials in the United States District Court for the Eastern District of Arkansas seeking a declaratory judgment. App. 3. Specifically, Ahlborn argued that the Department could recover only that portion of the settlement proceeds that represented payment for past medical expenses as opposed to the full amount that the Arkansas Medicaid program had actually paid to her or on her behalf for her medical care resulting from the accident. *Id.* Ahlborn based her argument on a provision of federal Medicaid law – often called the "anti-lien provision" or

[1] "R." refers to the page of the Joint Appendix filed in *Ahlborn v. Arkansas Dep't of Human Services, et al.*, filed in Case No. 03-3377 before the United States Court of Appeals for the Eighth Circuit.

"anti-lien statute" – that prohibits the imposition of a lien "against the property of any individual prior to [her] death on account of medical assistance paid or to be paid on his behalf under the State plan." App. 3, 5. The Department contended that the anti-lien provision did not prevent full recovery, arguing that because Ahlborn had assigned to it as a condition of Medicaid eligibility her "right to any settlement, judgment, or award" paid by a third party liable for her medical costs resulting from the accident, that the settlement proceeds remained the "property" of the third-party tortfeasor until the Medicaid program was fully reimbursed for the funds that it expended on Ahlborn's medical care. App. 5, 6. The Department also explained that if Ahlborn's unliquidated tort claim constituted "property" at the time that she applied for Medicaid, it would have been a "resource" that would have made her ineligible for Medicaid benefits. App. 7 & n. 1.

Adopting the Department's reasoning, the district court held that the federal anti-lien provision did not prevent the Department from recovering from the settlement proceeds the full amount that the Arkansas Medicaid program had paid for Ahlborn's medical care. App. 29, 30. The United States Court of Appeals for the Eighth Circuit overturned this ruling, however, finding that any settlement money that represented something other than compensation for medical care remained Ahlborn's "property" and was thus protected by the anti-lien provision. App. 14.

A. Federal Statutory And Regulatory Background

1. The Medicaid Program In General

Enacted in 1965 as Title XIX of the Social Security Act ("Act"), Medicaid is a publicly funded program that pays for needed medical care for people whose income and resources are insufficient to meet the cost of the required care. *See generally* 42 U.S.C. §§ 1396-1396v; *Atkins v. Rivera*, 477 U.S. 154, 156 (1986) (citation omitted). The primary purpose of the Medicaid program is to provide federal financial assistance to states that elect to reimburse certain costs of

medical treatment for needy individuals. *Harris v. McRae*, 448 U.S. 297, 301 (1980). Congress intended Medicaid to be "the payer of last resort, that is, other available resources must be used before Medicaid pays for the care of an individual enrolled in the Medicaid program." *See e.g.*, S. Rep. No. 99-146 at 312 (1985), *reprinted in* 1986 U.S.C.C.A.N. 42, 312. Sound policy and fiscal considerations underlie Congress's intent, including ensuring that sufficient funds remain for future Medicaid recipients and lessening the burden on state and federal taxpayers. *See Schweiker v. Gray Panthers*, 453 U.S. 34, 48 (1981) (recognizing "[t]here are limited resources to spend on welfare.").

States such as Arkansas that choose to participate in the Medicaid program, which is jointly funded by the federal and state governments, must comply with the Act's requirements and with regulations promulgated by the United States Secretary of Health & Human Services ("HHS"). *See e.g., Schweiker*, 453 U.S. at 37; 42 C.F.R. § 430.0 (2004). The federal government may penalize a state's non-compliance by a reduction in or the complete withholding of federal funding to the state. *See* 42 C.F.R. §§ 430.35(a)(1) (2004) and 433.140(a)(1) (2004). HHS's Centers for Medicare and Medicaid Services ("CMS"), previously known as the Health Care Financing Administration ("HCFA"), administers the Medicaid program federally. *See generally* 42 C.F.R. §§ 430.0-430.48 (2004). Participating states must submit for CMS's approval a state Medicaid plan. *See generally* 42 U.S.C. § 1396a (2000).

In determining whether an individual is eligible to receive Medicaid, Congress instructed states to consider an individual's income and resources. Although Congress did not define "resources" affirmatively, it excluded from the definition of "resources" certain categories of property. 42 U.S.C. § 1382b(a) (2000). There is nothing in the language of the Act that excludes from "resources" an unliquidated tort claim against a third party. *Id.*

2. Third Party Recovery And Assignment Provisions

The Social Security Act does not authorize the federal government to recover Medicaid expenditures directly from third parties. Instead, the Act protects the federal fisc by explicitly requiring participating states to pursue reimbursement of state and federal medical assistance payments when third parties are responsible for the injuries underlying those expenses. Upon a state's recovery of these expenses, the Act requires that it reimburse CMS for the federal portion of the payments. For example, federal law requires that states take "all reasonable measures to ascertain the legal liability of third parties . . . to pay for care and services under the plan" and seek reimbursement "to the extent of such liability." 42 U.S.C. § 1396a(a)(25)(A), (B) (2000). Specifically, the Act requires that:

> In any case where a third party has a legal liability to make payment for [medical] assistance, the State has in effect laws under which, to the extent that payment has been made under the State plan for medical assistance for health care items or services furnished to an individual, *the State is considered to have acquired the rights of such individual to payment by any other party* for such health care items or services.

42 U.S.C. § 1396a(a)(25)(H) (2000) (emphasis added).

In addition, the Act mandates that each state must require that Medicaid recipients, as a condition of eligibility, assign to the state their rights to payment for medical care from any liable third party. Specifically, 42 U.S.C. § 1396k(a)(1)(A) provides in pertinent part:

> A State plan for medical assistance shall –
>
> (1) provide that, as a condition of eligibility for medical assistance under the State plan to an individual who has the legal capacity to execute an assignment for himself, the individual is required –

> (A) to assign the State any rights, of the individual or of any other person who is eligible for medical assistance under this subchapter and on whose behalf the individual has the legal authority to execute an assignment of such rights to . . . payment for medical care from any third party.

42 U.S.C. § 1396k(a)(1)(A) (2000). This provision also places a duty on the recipient to "cooperate with the State" in identifying and helping the State to pursue potentially liable third parties. 42 U.S.C. § 1396k(a)(1)(C) (2000).

The federal assignment provision further mandates that states must be the first to be paid from any third party recovery. Once the state receives reimbursement for medical assistance benefits that it paid to a Medicaid recipient, any remaining amount must be paid to the recipient. Specifically, 42 U.S.C. § 1396k(b) requires:

> [s]uch part of any amount collected by the State under an assignment . . . shall be retained by the State as is necessary to reimburse it for medical assistance payments made on behalf of an individual with respect to whom such assignment was executed (with appropriate reimbursement of the Federal Government to the extent of its participation in the financing of such medical assistance), and the remainder of such amount collected shall be paid to such individual.

42 U.S.C. § 1396k(b) (2000).

3. The "Anti-Lien Provision"

A separate provision of the Act, which is commonly referred to as the "anti-lien provision," protects a Medicaid recipient's property from liens related to medical expenditures made under the program during the recipient's lifetime. 42 U.S.C. § 1396p(a)(1) (2000). In relevant part, this provision provides that "[n]o lien may be imposed against the property of any individual prior to his death on

account of medical assistance paid or to be paid on his behalf under the State plan." *Id.*

B. Arkansas's Compliance With The Act's Recovery And Assignment Provisions

Arkansas participates in the federal Medicaid program and has designated the Arkansas Department of Human Services as the single state agency responsible for administrating the State plan. *See* Ark. Code Ann. § 20-76-201(1) (2001). In compliance with the Social Security Act, Arkansas enacted laws under which the State acquires the rights of a Medicaid recipient to receive payments from third parties who are legally liable for the recipient's medical costs; thus, the State receives reimbursement for the medical assistance benefits that it provided to the recipient. *See generally* Ark. Code Ann. § 20-77-301 *et seq.* (addressing third-party liability for medical assistance benefits paid by the Arkansas Medicaid program).

As required by the federal assignment provision, Arkansas law mandates that Medicaid recipients, as a condition of eligibility for benefits, assign to the State their rights to certain payments from liable third parties. Arkansas's assignment and recovery statute provides in pertinent part:

> (a) As a condition of eligibility, every Medicaid applicant shall automatically assign his or her right to any settlement, judgment, or award which may be obtained against any third party to the [State] Department of Human Services to the full extent of any amount which may be paid by Medicaid for the benefits of the applicant.
>
> (b) The application for Medicaid benefits shall, in itself, constitute an assignment by operation of law.
>
> (c) The assignment shall be considered a statutory lien on any settlement, judgment, or award received by the recipient from a third party.

Ark. Code Ann. § 20-77-307(a)-(c) (2001).

C. Procedural History

1. United States District Court For The Eastern District Of Arkansas

The Department and Ahlborn filed cross motions for summary judgment in the United States District Court for the Eastern District of Arkansas. App. 16. The parties agreed that the issue in the case – the extent to which the State could recover Medicaid benefits that it had paid on Ahlborn's behalf from the personal injury lawsuit settlement – was an issue of statutory construction for the Court. *Id.*[2] In a Judgment entered August 22, 2003, the district court granted summary judgment in favor of the Department, holding that "the Medicaid statute is intended to vest States with the right to recover the full payment of medical expenses by a third party liable for causing the injuries which triggered the need for medical care." App. 30.

As an initial matter, the district court recognized that federal Medicaid statutes were enacted as part of a publicly funded program to provide medical care to individuals lacking the resources to obtain essential medical services, and that the Medicaid program was intended to be the "payer of last resort." App. 19. The district court likewise noted that the State of Arkansas, which subjected itself to compliance with the mandates of the Act and regulations promulgated thereunder by voluntarily electing to participate in this program, enacted its assignment and recovery statute in compliance with the federal mandate set forth in 42 U.S.C. § 1396k. App. 20-21. The court then rejected Ahlborn's argument that the Act's anti-lien provision

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[2] Because Ahlborn and the third parties had not allocated the settlement proceeds among Ahlborn's various claims (i.e., permanent injury, past and future medical expenses, pain and suffering, etc.), the parties to the federal lawsuit stipulated to an allocation in order to enable the federal court to rule on cross motions for summary judgment as a matter of law. App. 16, 17.

limited the Department's right to full reimbursement from the settlement proceeds.

First, the court reasoned that a personal injury settlement that a Medicaid applicant assigns to the Department as a condition of eligibility for medical assistance benefits is not the "property" of the Medicaid beneficiary within the meaning of the anti-lien provision. App. 22, 23, 30. Adopting the reasoning of the highest courts of Utah and Washington, as well as the dissenting opinion of the highest court in Minnesota, the district court explained that "the anti-lien provision drops out of the analysis once a Medicaid recipient assigns his cause of action because the recipient no longer has any interest in the property (his or her action against third parties) to the extent of the state's expenditures." App. 26 (citations omitted).

Next, the district court recognized that the United States Secretary of Health and Human Services, whose federal agency is charged with administering the Medicaid laws in question, has consistently interpreted the Act in the same manner as the State of Arkansas. App. 27. Specifically, the court recognized that the Secretary, which "has not hesitated to enforce its position against participating States," has taken the position that "States must require, as a condition of eligibility, that recipients assign to the State their right to recover from third parties and that, from any such recovery, the State must recover the full amount of benefits paid on the behalf of the recipient." *Id.* (citations omitted). In finding the Secretary's position entitled to "due consideration," the district court cited to cases in which the United States Supreme Court recognized the Secretary's "significant expertise" in the context of this "complex and highly technical regulatory program," and granted the Secretary "exceptionally broad authority" under the Medicaid statute. App. 28 (citations omitted).

Finally, the district court explained that if Ahlborn's lawsuit had been litigated to conclusion or reduced to a sum certain at the time that she had applied for Medicaid benefits, she would have been forced to expend those

monies, or "resources," before she would have qualified for Medicaid benefits. *Id.* The court reasoned that Congress instructed states to consider a Medicaid applicant's income and resources in determining whether the individual is eligible to receive Medicaid benefits. App. 28, 29, *citing* 42 U.S.C. § 1382b. Although Congress excluded certain categories of property from the definition of "resources," the court found that it did not exclude an unliquidated tort claim against a third party. *Id.* The district court thus concluded that a Medicaid applicant's unliquidated tort claim is both a "resource" and "property" for purposes of the Medicaid Act, and consequently, "there is nothing incongruent about requiring an applicant, as a condition of Medicaid eligibility, to assign to the State his entire 'rights to payment from third parties.'" App. 29.

Summarizing its reasoning in support of the Department's interpretation of the Act, the district court explained:

> Section 1396a(a)(25), which [Ahlborn] construes as limiting Arkansas' right of assignment, is harmonized with the remainder of the Medicaid statute by a broader reading. The Medicaid statute requires States to ascertain the "legal liability" of third parties "to pay for care and services" rendered under the Medicaid program, 42 U.S.C. § 1396a(a)(25)(A), and, to pursue recovery to the full "*extent of such legal liability*," 42 U.S.C. § 1396a(a)(25)(B) [district court's emphasis]. Full effect to the statute as a whole is supported by an interpretation of the statutory provisions that does not limit States to the compromise value assigned to the medical expenses component of the assigned claim during settlement negotiations . . . [a]lthough the statutory language in question is far from a model of clarity, when the Court considers the statute as a whole, the Secretary's position on the issue, and the legislative history of the Medicaid statute . . . it concludes that the [Department] ha[s] the better argument. The Medicaid statute is intended to vest States with the right to recover the full payment of medical

> expenses by a third party liable for causing the injuries which triggered the need for medical care.

App. 29-30.

2. United States Court Of Appeals For The Eighth Circuit

The United States Court of Appeals for the Eighth Circuit reversed the district court, finding that "Ahlborn ha[d] the better of the argument." App. 2. Like the district court, the court of appeals recognized that Congress intended Medicaid to be a "payer of last resort," and that the "primary purpose of the [Medicaid] program is to provide federal financial assistance to States that elect to reimburse certain costs of medical treatment for needy individuals." App. 4 (citations omitted). Contrary to the district court, however, the Eighth Circuit found that Ahlborn's unliquidated tort claim remained her "property," and that the federal anti-lien provision thus preempted Arkansas's assignment and recovery statutes "to the extent that they require Ahlborn to assign her rights to recover third-party liability payments for matters other than the cost of her medical care and services." App. 14.

In so ruling, the Eighth Circuit found that the State's assignment and recovery statute "requires recoupment from, and places a lien on, the entirety of third-party payments – not just that portion of the third-party payment for medical care." App. 5. The court rejected the State's argument that its assignment and recovery statute did not conflict with the federal anti-lien provision because federal law *mandates* that states participating in the Medicaid program impose such a reimbursement mechanism. App. 5-6. Turning to 42 U.S.C. § 1396a(25)(H) and 42 U.S.C. § 1396k(a)(1), the court reasoned that the Act mandates only that participating states recover payments made by third parties "to compensate for medical care." App. 10. Specifically, the court explained:

> [w]e believe a straightforward interpretation of the text of these statutes demonstrates that the

> federal statutory scheme requires only that the State recover payments from third parties to the extent of their legal liability to compensate the beneficiary *for medical care and services* incurred by the beneficiary. Under § 1396a(a)(25)(H), a state Medicaid plan must include provisions specifying that, when the State provides medical benefits to an applicant, "the State is considered to have acquired the rights of such individual to *payment by any other party for such health care items or services.*" [court's emphasis]. The acquisition of rights occurs only in cases where a "third party has a legal liability to make payment for [medical] assistance." *Id.* Section 1396k(a)(1)(A) similarly requires that an applicant assign to the State her right "to *payment for medical care* from any third party." [court's emphasis]. Both statutes are thus limited to rights to third-party payments made to compensate for medical care.

App. 9-10.

In so ruling, the Eighth Circuit refused to defer to the HHS Secretary's (HCFA/CMS's) interpretation and implementation of the federal third-party liability provisions. App. 11. Initially, the court recognized that the Secretary's interpretation had twice been upheld by the HHS's Department of Appeals Board ("DAB"). App. 10, 11. Despite its acknowledgement that the Secretary is charged with administering the Act and is entitled to deference "when a statute is ambiguous and the agency advances a reasonable interpretation of the statute," the court found that the agency's interpretation was "inconsistent with the plain language of the [Act]" and thus not entitled to deference. App. 11, *citing Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842-43 (1984).

Finally, the court found that Ahlborn's unliquidated cause of action was not a "resource" that should have been considered in determining her Medicaid eligibility. App. 7 & n. 1. Reasoning that a "resource" in this context is defined as "cash or other liquid assets or any real or

personal property that an individual . . . owns and could convert to cash to be used for his or her support or maintenance," *citing* 20 C.F.R. § 416.1201(a), the court found that Ahlborn lacked the power to convert her cause of action to cash when she applied for Medicaid benefits. App. 7 & n. 1, 8 (citation omitted). The court thus concluded that "although the same cause of action was 'property' . . . it was not a 'resource.'" *Id.* (citations omitted).

ARGUMENT

A. Certiorari Is Appropriate Because A Substantial Conflict Exists Between *Ahlborn* And Decisions Of Several Other Courts

The Eighth Circuit's opinion in *Ahlborn* directly conflicts with rulings of the highest courts of Washington, Utah, and New York, all of which held within the context of the anti-lien provision that states may recover the full amount of Medicaid benefits paid to a recipient from settlement proceeds from a third party who caused the recipient's injuries that necessitated the medical care expenditures. *Wilson v. State*, 10 P.3d 1061 (Wash. 2000), *cert. denied*, 523 U.S. 1020 (2001); *Houghton v. Department of Health*, 57 P.3d 1067 (2002), *cert. denied*, 538 U.S. 945 (2003); *Cricchio v. Pennisi*, 683 N.E.2d 301 (N.Y. 1997) and *Calvanese v. Calvanese*, 710 N.E.2d 1079 (N.Y. 1999), *cert. denied*, 528 U.S. 928 (1999). It likewise conflicts with decisions of the United States Court of Appeals for the Second Circuit and the Supreme Court of North Dakota that federal law authorizes states to obtain *full* reimbursement from third party settlements for the cost of medical benefits paid to a Medicaid recipient. *Sullivan v. County of Suffolk*, 174 F.3d 282 (2nd Cir. 1999), *cert. denied*, 528 U.S. 950 (1999); *Grey Bear v. North Dakota Dept. of Human Services*, 651 N.W.2d 611 (N.D. 2002). Although the recipients in *Sullivan* and *Grey Bear* did not raise the federal anti-lien provision, the courts' reasoning readily transfers to the anti-lien context.

The Minnesota Supreme Court, however, has ruled in a manner consistent with the *Ahlborn* court. *Martin v. City of Rochester*, 642 N.W.2d 1 (Minn. 2002), *cert. denied*, 539 U.S. 957 (2003). Due to this conflict over an area of federal law that significantly impacts every state, this often-litigated and critically important issue is ripe for review by this Court.

1. The *Ahlborn* Decision Conflicts With Decisions Of The Highest Courts Of Utah, Washington, And New York That Directly Addressed The Federal Anti-Lien Provision

a. *Wilson v. State* (Supreme Court Of Washington)

In *Wilson v. State*, a guardian *ad litem* brought an action on behalf of a class Medicaid recipients who had filed personal injury lawsuits and received either settlements or judgments in their favor. 10 P.3d 1061, 1063 (Wash. 2000), *cert. denied*, 523 U.S. 1020 (2001). The question before the Supreme Court of Washington was whether state law "which attempts to lien a Medicaid recipient's third party recovery beyond that portion specifically allocated to medical expenses, conflicts with the federal [anti-lien] law and is thus preempted." *Id.* at 1063. Finding no conflict, the court concluded that "the state is not limited to recovery from only that portion of the settlement specifically allocated to medical expenses . . . [t]he federal statute states recovery is to the extent of payment made by the state for health care items or services." *Id.* at 1066.

Addressing the federal anti-lien provision, the court recognized that federal law permitted a statutory assignment of rights to third party payments, and that the Medicaid recipients "assigned the right to payment to the extent paid out by the state." *Id.* at 1064-66. The court explained that because the state's lien was placed on the recovery "before it becomes the property of the Medicaid recipient . . . the [state] does not have a lien on 'property' of the recipient." *Id.* at 1066. The court thus found the federal anti-lien provision to be "irrelevant." *Id.* at n. 2.

b. *Houghton v. Department Of Health* (Supreme Court Of Utah)

In *Houghton v. Department of Health*, the Supreme Court of Utah considered whether the state may place a "priority lien" on third party settlements paid to Medicaid recipients that enable the state to receive full reimbursement for medical costs paid to the recipient before the recipient receives compensation for non-medical claims. 57 P.3d 1067, 1069 (Utah 2002), *cert. denied*, 538 U.S. 945 (2003). Rejecting the recipient's argument that such a lien "could result in a seizure of the recipient's property," the court held that the priority lien did not run afoul of the federal anti-lien provision. *Id.* at 1069.

Citing to the federal anti-lien provision, the court explained that "[i]t is well settled in Utah that liens against third-party settlement proceeds do not violate federal law because settlement payments do not become a recipient's property until Medicaid is reimbursed." *Id.* at 1069 (citations omitted). Thus, the court concluded that "a priority lien on a recipient's third-party settlement proceeds does not encumber the recipient's property, even if those proceeds include compensation for nonmedical claims." *Id.* at 1069.

c. *Cricchio v. Pennisi* And *Calvanese v. Calvanese* (New York)

In *Cricchio v. Pennisi*, New York's highest court considered whether a Medicaid lien placed by the state "on the proceeds of a personal injury settlement must be satisfied before those funds may be transferred to a 'supplemental needs trust.'" 683 N.E.2d 301, 302 (1997). Medicaid recipients argued that the Medicaid lien could not be satisfied until after their deaths based upon the federal anti-lien provision. *Id.* at 304-05. Rejecting that contention, the *Cricchio* court found that because the injured Medicaid recipients had assigned their recovery rights to the state as required by 42 U.S.C. § 1396k, "the settlement proceeds are resources of the third-party

tortfeasor that are owed to [the state]." *Id.* at 305. The court further explained:

> Accordingly, the lien on the settlement proceeds attaches to the property of the third party, and thus does not violate the statutory prohibition against imposing a lien against a beneficiary's property until after his or her death . . . The flaw in the plaintiff's theory that the lien cannot be satisfied until the recipient's death is that it fails to appreciate this critical distinction between the assets of a responsible third party and assets belonging to the Medicaid recipient.

Id. (citations omitted). In so ruling, the court recognized that "the legal liability of any responsible third party to reimburse Medicaid for care . . . is a cornerstone of the Medicaid program." *Id.*

The *Cricchio* court left open the question of whether the entire amount of a personal injury settlement or only that portion attributable to past medical expenses was available to reimburse the state. This question was later addressed in *Calvanese v. Calvanese*, however, in which New York's highest court considered whether "the entire amount of a personal injury settlement [was] available to satisfy a Medicaid lien, or only that portion of the settlement specifically allocated to past medical expenses." 710 N.E.2d 1079 (N.Y. 1999), *cert. denied*, 528 U.S. 928 (1999). The appellants, who had received Medicaid benefits for injuries allegedly suffered due to the negligence of third parties, commenced personal injury actions against the third parties. *Id.* at 1080. When the lawsuits settled, the recipients refused to satisfy the Medicaid liens placed upon the settlements, arguing that the settlement proceeds were designated as payment for "pain and suffering." *Id.*

After analyzing the federal assignment and third party recovery provisions set forth in 42 U.S.C. §§ 1396a(a)(25)(H) and 1396k(b), the court rejected the recipients' argument that only the settlement proceeds specifically allocated to past medical expenses should be made available to satisfy the state's Medicaid lien. *Id.* at 1082. It found that "[n]owhere in the elaborate statutory

scheme governing this area of the law . . . is the agency's right of recovery restricted in this matter." *Id.* at 1081. The court further reasoned that creating such a restriction on the state's ability to recover its Medicaid expenditures "would weaken the assignment and subrogation provisions as well as the priority assigned to Medicaid liens, results that would jeopardize the ultimate goal of Medicaid – that the program be the payer of last resort." *Id.* at 1082. The court also recognized that restricting the state from recovering its medical expenditures from the settlement proceeds "would also create an anomalous situation"; specifically, "Medicaid applicants could be disqualified from eligibility for financial resources that include prior personal injury settlements allocated to pain and suffering, but Medicaid recipients could shield such funds from recoupment by the [state] after having received significant public assistance." *Id.* at 1082.

2. The *Ahlborn* Decision Conflicts With Decisions Of The Second Circuit And The Supreme Court Of North Dakota That Addressed The States' Right To Full Reimbursement For Medical Expenses From Third-Party Settlements

a. *Sullivan v. County Of Suffolk* (United States Court Of Appeals For The Second Circuit)

In *Sullivan v. County of Suffolk*, the Second Circuit held that, based upon the federal assignment statute, a state may first satisfy its lien before any settlement proceeds are placed in a supplemental needs trust for a Medicaid recipient. 174 F.3d 282, 286 (2nd Cir. 1999), *cert. denied*, 528 U.S. 950 (1999). In so holding, the court interpreted the federal assignment language to mean that the Medicaid recipient had "assigned his right to recover from a third party to [the state], *up to the amount of medical assistance provided.*" *Id.* (emphasis added). The court further noted that "the agency is entitled to full recovery once sufficient funds are made available by a responsible third party, regardless of what portion of the settlement is allocated to past medical expenses." *Id.* at

286, n. 5 (*citing Calvanese*, 93 N.Y.2d at 479, 484, 710 N.E.2d 1079).

b. *Grey Bear v. North Dakota Dept. Of Human Services* (North Dakota)

In *Grey Bear v. North Dakota Dept. of Human Services*, the Supreme Court of North Dakota likewise held that the state's recovery of medical assistance paid on behalf of a Medicaid recipient should not be limited to that portion of settlement proceeds allocated to medical expenses, but may extend to settlement proceeds intended to compensate the recipient for pain and suffering. 651 N.W.2d 611, 615 (N.D. 2002). Turning to the federal assignment statutes and state law enacted in response, the court rejected a Medicaid recipient's argument that he had made only a "partial assignment" under the law that encompassed only claims for medical costs but not for pain and suffering. *Id.* at 615. In so ruling, the *Grey Bear* court adopted the reasoning set forth in cases such as *Wilson* and *Calvanese* that reimbursement for medical costs paid is not limited "to recovery allocated specifically to medical costs," and that "nowhere in the elaborate scheme governing Medicaid is the agency's right to recovery restricted" to settlement proceeds "specifically allocated to past medical expenses." *Id.* at 615-66, 622 (citations omitted).

3. The *Ahlborn* Decision Is Consistent With That Of The Supreme Court Of Minnesota

In *Martin v. City of Rochester*, the Minnesota Supreme Court held in a 4-3 decision that Minnesota's assignment and recovery statute was conflict preempted by the federal anti-lien provision to the extent that it permitted the state to obtain an assignment from a Medicaid recipient for anything more than the recipient's "rights to payment for medical care from third parties liable for the injuries that necessitated medical assistance." 642 N.W.2d 1, 18 (Minn. 2002), *cert. denied*, 539 U.S. 957 (2003). In so holding, the court recognized that a Medicaid recipient who assigns his right to recovery no longer holds any "property" right in

the recovery, "and therefore the anti-lien provision does not prohibit a state from pursuing recovery under this assigned right." *Id.* at 13, 14. Reasoning consistently with the Eighth Circuit in *Ahlborn*, however, the *Martin* court determined that the assignment mandate contained in §§ 1396k and 1396a(a)(25)(H) is limited to the assignment of proceeds from a third party for medical care only. *Id.* at 12-13.

The court further held that Minnesota's statutes conflicted with the purpose of the anti-lien provision, which is "to protect the recipient's limited assets, including nonassigned rights to recover." *Id.* at 18. Thus, the court narrowly construed the federal assignment statutes to mean that the state had assignment rights to "all proceeds *for medical care*, but does not have rights in any other part of a recovery." *Id.* at 19 (court's emphasis). Stated differently, the court found that the state cannot recover the full amount of Medicaid benefits that it paid to a recipient, but rather only portions of the recovery that had not been designated as reimbursement for non-medical care damages. *Id.* at 26.

In reaching this result, the *Martin* court (like the *Ahlborn* court) accorded no deference to the United States Department of Health and Human Services interpretations and adjudications concerning the states' ability to use such measures to recover medical expenditures from responsible third parties. *Id.* at 21. Noting that "[d]eference to agency interpretation is called for . . . only when there is an ambiguity in the expression of congressional intent," the court concluded that the statutory scheme at issue was not ambiguous. *Id.* at 21.

B. Certiorari Is Appropriate Because *Ahlborn* Conflicts With Adjudications And Interpretations Rendered By The United States Department Of Health And Human Services

The *Ahlborn* decision directly conflicts with interpretations rendered by the United States Department of Health & Human Services ("HHS"), as well as adjudications of its Departmental Appeals Board ("DAB"). Formal federal agency adjudications, such as those issued by DAB,

are granted full deference when the language of a statute is ambiguous or silent on a particular issue and the interpretation is a permissible construction of the statute.[3] *Chevron, U.S.A. Inc. v. Natural Resources Defense Council*, 467 U.S. 837, 843 (1984). Agency interpretations not contained in regulations or adjudications are due a "respect proportional to [their] 'power to persuade'" given the "'specialized experience and broader investigations and information' available to the agency." *United States v. Mead Corp.*, 533 U.S. 218, 234-35 (2001) (*quoting Skidmore v. Swift & Co.*, 323 U.S. 134, 139-40 (1944)).

The United States Supreme Court addressed the level of deference accorded to HHS interpretations of Medicaid program provisions in *Wisconsin Dep't of Health and Family Services v. Blumer*, 534 U.S. 473 (2002). In *Blumer*, this Court held that Wisconsin's use of an "income first" method, which HHS had specifically authorized in a "Regional State Letter," was a permissible approach under federal law for determining an institutionalized spouse's Medicaid eligibility. Upholding the method, this Court noted that respectful consideration of a federal agency's interpretation is especially appropriate for the federal Medicaid agency based upon its "significant expertise" in "a complex and highly technical regulatory program." *Id.* at 497 (*quoting Thomas Jefferson Univ. v. Shalala*, 512 U.S. 504, 512 (1994)). Furthermore, this Court recognized the long-standing principle that Congress delegated

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[3] HHS's adjudications and interpretations satisfy the second prong of the *Chevron* test, which requires that the agency's interpretation be a "permissible construction of the statute." 467 U.S. at 843. These adjudications and interpretations are permissible because they underscore the federal law requirement that states be given broad authority to pursue third party recoveries. *See* 42 U.S.C. § 1396a(a)(25)(A) (2000); *Wisconsin Dep't of Health and Family Services v. Blumer*, 534 U.S. 473 (2002) (allowing for a permissible range of choices to the States in implementing the Medicaid program where HHS has found that such latitude is consistent with the statute's aims). Furthermore, HHS's adjudications and interpretations support Congress's intent that Medicaid be the "payer of last resort." Senate Report No. 99-146, at 312 (1985), *reprinted in* 1986 U.S.C.C.A.N. 42, 279. App. 44.

"extremely broad regulatory authority to the Secretary [of HHS] in the Medicaid area." *Id.* at 497, n. 13. Accordingly, this Court observed that "the leeway for state choices urged by both Wisconsin and the United States is characteristic of Medicaid." *Id.* at 476.

1. HHS's Departmental Appeals Board Decisions, Which Are Entitled To Deference, Conflict With The *Ahlborn* Decision

The *Ahlborn* court failed to accord appropriate deference to two decisions of HHS's DAB concerning the breadth of the federal assignment provision. In *California Dep't of Health Services*, HCFA (CMS's predecessor) opposed California's practice of permitting recipients to keep portions of third party recoveries that did not represent payment for medical care. DAB No. 1504 (1995); App. at 68. The DAB upheld HCFA's interpretation, concluding that federal Medicaid law requires full Medicaid reimbursement before a recipient may collect any proceeds from a third party settlement. App. at 69, 75. In so ruling, the DAB explained that HFCA's position was "directly supported" by the Social Security Act; specifically:

> [r]ecipients, as a condition of eligibility, must assign their rights to payment for medical care. States are then charged with the responsibility of seeking third party recovery pursuant to such assignments. States are further required to seek as much reimbursement as possible, i.e., to the extent of the third party's liability. Finally, when a recovery is made, the Act sets forth a distribution scheme which requires the Medicaid program to be reimbursed prior to distributing any funds to the recipient. While [42 U.S.C. § 1396k(a)] refers to assignment only of "payment for medical care," the statutory scheme as a whole contemplates that the actual recovery might be greater and, if it is, that Medicaid should be paid first.

App. at 76 (emphasis added). The DAB also recognized that this position was not unfair to the Medicaid recipients:

> If Medicaid had not paid their medical expenses, these recipients would have both unrestricted access to their settlements and enormous medical debts to be paid from those settlements . . . where Medicaid has incurred the "debt" for recipients, it is not unfair for HCFA to require complete reimbursement from these liability funds.

App. at 85.

The DAB reached a similar result in *Washington State Dep't of Social & Health Svs.*, in which it upheld HCFA's determination that, under the mandatory federal assignment provision, Medicaid must be reimbursed in full before the recipient receives any settlement monies. DAB No. 1561 (1996); App. at 45. The Board explained:

> Where there is a third party that is responsible for payment of a recipient's medical expenses, the recipient may not recover money for him/herself until the federal government is reimbursed for its expenditure of the recipient's medical care.
>
> . . .
>
> HCFA may require a state to assert a collection priority over funds obtained by Medicaid recipients in [third party liability] suits even though the distribution methodology set forth in [42 U.S.C. § 1396k(b)] refers only to payments collected pursuant to assignments for medical care.

Id. The DAB further stated unequivocally: "In cases where a third party has caused the need for medical care and is liable for payment, the Act looks to the third party to reimburse the public." *Id.*

2. HHS's Interpretation Of Medicaid Law, Which Is Entitled To Deference, Allows States To Place Liens On Settlements With Third Parties For The Full Amount That The Program Paid To The Recipient

Additionally, HHS, through HCFA/CMS, has clearly and repeatedly confirmed that the federal anti-lien provision does not prohibit states from placing liens on

third party settlement proceeds to compensate the Medicaid program for the entire amount of medical costs that it paid to a recipient. For example, HCFA explained in a letter to states issued September of 1994 that although federal law prohibits a state "from imposing liens against the property of an individual prior to his/her death because of medical assistance paid on his/her behalf," states are nonetheless required to seek reimbursement from the proceeds of any legal action brought by the recipient "even though [the state] may not have been a party to the litigation." HCFA letter entitled "Third Party Liability Relationship to Liens" (issued September 2, 1994), App. 87, 88. In this letter, HCFA instructed:

> [states] have an interest in the potential personal injury settlement when a recipient's right to recover payment for medical care must have been assigned to [the state] . . . in order for him/her to be eligible for Medicaid. In that event, if you place a lien on these funds, it does not violate the [federal anti-lien] statute.

App. 88.

Likewise, in an HHS letter to states issued in June of 1998 the agency left no doubt that a Medicaid recipient has a right "only to the remainder" of any recovery from a liable third party "after Medicaid payments are fully reimbursed." HCFA letter entitled "State Third Party Liability (TPL) Subrogation Legislation" (issued June 1, 1998), App. 91. The letter instructed that the Social Security Act "does not authorize any payments to the recipient until Medicaid is fully repaid." *Id.*

C. Certiorari Is Appropriate Because This Case Involves An Important Question Of Federal Law That Has Not Been, But Should Be, Settled By This Court

A ruling by this Court regarding a state's authority under federal law to recover the full amount of its Medicaid dollars expended from third party settlement proceeds through use of existing third party recovery methods

such as liens is an issue that has been regularly litigated over the past several years, is of major significance to the states for both financial and planning purposes, and is one that is ripe for review by this Court.

1. This Case Presents A Question Of Significant National Importance

The often litigated issue[4] in this case is of significant national concern, particularly at a time when the level of federal funding of the Medicaid program is decreasing. The *Ahlborn* decision calls into question the legitimacy of assignment and recovery statutes throughout the country, and likewise challenges the ability of all states to define the manner in which they will recover Medicaid expenditures as required under federal law. For apparent fiscal reasons, federal law requires Medicaid participating states to pass laws to ensure that the state acquires the rights of a Medicaid recipient to receive reimbursement from any third party who is liable for medical costs that the Arkansas Medicaid program paid on behalf of the recipient. 42 U.S.C. § 1396a(a) (2000); 42 U.S.C. § 1396k(a), (b) (2000). These same laws allow the states to define the manner in which they will recover these payments. Nothing in the federal Medicaid statutes, however, supports the *Ahlborn* court's finding that the federal anti-lien provision limits the state's recovery to that portion of a settlement that is designated or allocated as recovery for medical expenses.[5]

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[4] *See supra* at 16-21; *see also Padgett v. Toal*, 81 S.E.2d 744, 745-46 (Ga. Ct. App. 2003) (state entitled to recover the full amount of medical costs paid to Medicaid recipient from proceeds of third party personal injury settlement award; full recovery does not run afoul of federal anti-injunction provision).

[5] In the contexts of Medicare and the Federal Employees Compensation Act, courts likewise have found the government entitled to full reimbursement. *See Zinman v. Shalala*, 67 F.3d 841 (9th Cir. 1995) (court rejected Medicare beneficiaries' argument that they were entitled to proportionate distribution of third party recoveries); *United States v. Lorenzetti*, 467 U.S. 167, 176 (1984) (finding government entitled to full reimbursement in FECA case, court explained "[a]t no point did

(Continued on following page)

The issue in the present case is not limited to a few states. To the contrary, every state has passed a lien, assignment, or subrogation law – or some combination of the three – in order to comply with the federal assignment mandate. Several state third party liability statutes, including Arkansas's, provide that the state is entitled to full recovery of medical assistance benefits paid to a Medicaid recipient before the recipient may retain any settlement proceeds for his or her other claims. *See e.g.*, Ark. Code Ann. § 20-77-307 (2001) (state lien is recoverable "to the full extent of any amount which may be paid by Medicaid for the benefits of the applicant"); Alaska Stat. § 47.05-075(a) (2001) (state lien is "upon any sum that may be due to the recipient of medical assistance from a third-party payor"); Cal. Welf. & Inst. Code § 14124.78 (2002) (state's claim is against "the entire amount of any settlement of the injured beneficiary's action or claim"); Mont. Code Ann. § 53-2-612(3)(a)(i) (2001) (state lien "applies to all money paid by a third party . . . regardless of whether the recovery is allocated by the parties or a court to any particular type or element of damages"); 62 Pa. Cons. Stat. § 1409(b)(11) (2001) ("the entire amount of any settlement of the injured beneficiary's action or claim . . . is subject to the department's claim for reimbursement").

Aside from the legal arguments that militate against the *Ahlborn* court's interpretation of federal Medicaid law, such full reimbursement makes perfect sense. A person injured by a third party who is not receiving Medicaid benefits remains liable to his or her medical providers for the full amount of medical services provided; there is no reason why an individual receiving Medicaid should be in a more favorable position. Full reimbursement likewise recognizes the reality that Medicaid dollars are far from being an endless resource and that money reimbursed to

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Congress suggest in its deliberations that the federal right of reimbursement was to be limited to particular categories of third-party recoveries").

the state from third parties may be used to aid other Medicaid applicants in need. The strained interpretation of federal Medicaid law provided by the *Ahlborn* and *Martin* courts, however, is antithetical to purpose and spirit of the Social Security Act: that Medicaid remain the "payer of last resort."

Furthermore, states whose highest courts (or federal district courts) adopt the *Ahlborn* court's reasoning will be forced to intervene directly into all ongoing litigation or file independent causes of actions against third party tortfeasors to recover their Medicaid expenditures.[6] This will result in a substantial increase in expenditures of staff time and financial resources by the State. Requiring states to pursue third parties directly to recover publicly funded medical costs, instead of using lien or subrogation statutes to do so, would force states to spend much more money to recover the same amount of funds. Of course, increased collection expenses reduce the ultimate return to the state and federal government of their medical assistance funds. Stated differently, the *Ahlborn* court's approach would dramatically increase litigation and recovery costs for states, thus leaving less money to return to the Medicaid program for use by applicants in need. In contrast, states whose highest courts (or federal courts) follow the HHS's interpretation of federal Medicaid law will not be forced to litigate their medical assistance third party claims directly, nor will they be prevented from recovering their full claims from a Medicaid recipient's settlement proceeds, regardless of whether those proceeds are designated for "medical care" or not.

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[6] In fact, the State of Arkansas *did* intervene in the state court action below but was not notified by either the plaintiff or third-party tortfeasor of the settlement negotiations. The plaintiff and third-party tortfeasor likewise failed to make the State a signatory to the settlement agreement, rather presenting the agreement to the State as a *fait accompli* and refusing to reimburse the State for the cost of the medical services that it had provided through the Medicaid program to Ms. Ahlborn.

2. The *Ahlborn* Decision Misinterpreted Federal Medicaid Law, Thereby Minimizing A Key Purpose Of The Social Security Act

Certiorari is also appropriate in the present case because *Ahlborn* misinterpreted federal Medicaid law in a way that undercuts the primary purpose of the Medicaid program: to serve as the payer of last resort. A basic principle of statutory construction provides that related statutes must be read *in pari materia*, keeping in mind the purpose of the entire federal scheme, *Erlenbaugh v. United States*, 409 U.S. 239, 243-44 (1972), a principle that the *Ahlborn* decision ignored. The *Ahlborn* court likewise erred in holding that Arkansas's assignment and recovery statute, which requires full reimbursement from third party settlements for a recipient's medical costs paid by the Medicaid program, was preempted by federal law.

The United States District Court for the Eastern District of Arkansas had correctly recognized that "[f]ull effect to the [Medicaid] statute as a whole is supported by an interpretation of the statutory provisions that does not limit States to the compromise value assigned to the medical expense component of the assigned claim during settlement negotiations." App. at 29-30. Overturning the district court, however, the Eighth Circuit erroneously interpreted the anti-lien provision in a manner that denied the Medicaid program its appropriate reimbursement and created a windfall for the recipient. This holding, which is inconsistent with interpretations of the law rendered by the United States Department of Health and Human Services and several other courts, is antithetical to Congress's intention that Medicaid remains the "payer of last resort."

CONCLUSION

For the reasons and based upon the authorities set forth above, the Petitioners respectfully request that the petition for a writ of certiorari be granted.

Respectfully submitted,

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APPENDIX – TABLE OF CONTENTS

Page

Ahlborn v. Arkansas Dep't of Human Services, et al., 397 F.3d 620 (8th Cir. 2005) ..... App. 1

Ahlborn v. Arkansas Dep't of Human Services, et al., 280 F.Supp.2d 881 (E.D. Ark. 2003) ..... App. 16

United States Code
42 U.S.C. § 1382b(a) ..... App. 32

Code of Federal Regulations
42 C.F.R. § 430.0 ..... App. 36
42 C.F.R. § 430.35(a) ..... App. 36
42 C.F.R. § 433.140(a)(1) ..... App. 37
42 C.F.R. § 447.302 ..... App. 37

Ark. Code Ann. § 20-76-201(1) ..... App. 37

Ark. Code Ann. §§ 20-77-301 through 307 ..... App. 38

S. Rep. No. 99-146, at 312 (1985), *reprinted in* 1986 U.S.C.C.A.N. 42, 279 ..... App. 44

HHS Departmental Appeals Board cases
Washington State Dep't of Social & Health Services, D.A.B. No. 1561 (1996) ..... App. 45
California Dep't of Health Services, D.A.B. No. 1504 (1995) ..... App. 68

September 1994 HCFA Memorandum to State Medicaid Directors entitled "Third Party Liability Relationship to Issue Of Liens" ..... App. 87

June 1998 HHS Memorandum to State Agencies Administering Approved Medical Assistance Plans entitled "State Third Party Liability (TPL) Subrogation Legislation ..... App. 90

397 F.3d 620

United States Court of Appeals, Eighth Circuit. Heidi AHLBORN, Appellant,

v.

ARKANSAS DEPARTMENT OF HUMAN SERVICES; Kurt Knickrehm, Director of the Arkansas Department of Human Services; Wayne Olive, Director of the Third Party Liability Unit; Roy Jeffus, Interim Director, Division of Medical Services of the Arkansas Department of Human Services, Appellees. **No. 03-3377.**

Submitted: April 13, 2004. Filed: Feb. 9, 2005.

H. David Blair, argued, Batesville, Arkansas (Phillip Farris, on the brief), for appellant.

Richard B. Dahlgren, argued, Little Rock, Arkansas, for appellee.

Before MORRIS SHEPPARD ARNOLD, RILEY, and COLLOTON, Circuit Judges.

COLLOTON, Circuit Judge.

Heidi Ahlborn appeals the district court's grant of summary judgment in favor of the Arkansas Department of Human Services and employees thereof (collectively "the State") in a dispute concerning the extent to which her recovery from a tortfeasor may be taken by the State as reimbursement for the cost of medical care and services provided to Ahlborn by the Medicaid program. After careful review of the various statutes involved, we conclude that Ahlborn has the better of the argument, and we therefore reverse.

I.

Ahlborn was seriously injured in a motor vehicle accident on January 2, 1996. As a result of this accident, she suffered severe personal injuries, especially to her head, which required extensive medical care and rendered her permanently disabled. While under treatment, Ahlborn applied and qualified for medical benefits under the Arkansas Medicaid program, administered in the State by appellee Arkansas Department of Human Services ("ADHS"). In applying for benefits, Arkansas law required Ahlborn to assign to ADHS her "right to any settlement, judgment, or award" she might receive from third parties, "to the full extent of any amount which may be paid by Medicaid for the benefit of the applicant." Ark.Code Ann. § 20-77-307(a). In total, ADHS provided Medicaid benefits to or on behalf of Ahlborn in the amount of at least $215,645.30, which fully relieved her debt to health care providers.

The parties agree that Ahlborn's injuries gave rise to claims other than past medical care, including loss of earnings and working time, pain and suffering, and permanent impairment of ability to earn in the future. The parties also stipulated that an estimate of Ahlborn's damages totals approximately $3,040,708.12. However, in mid-2002, Ahlborn was paid $550,000 following a compromise settlement reached through negotiations with her insurance company and third parties allegedly liable for her injuries. This was a lump-sum settlement that did not allocate Ahlborn's recovery among her various claims. The State was not a party to the settlement. The Director of ADHS asserted a lien against Ahlborn's settlement for the amount of benefits ADHS provided, pursuant to Arkansas

Code Sections 20-77-301 through 20-77-313 (third-party liability).

Ahlborn brought suit seeking a declaratory judgment, arguing that ADHS can only recover that portion of her settlement representing payment for past medical expenses. The parties characterize the sole issue in this case as one of statutory construction: whether federal Medicaid statutes, which provide for the assignment of rights to third-party payments, but prohibit placing a lien on a Medicaid recipient's property, limit the State's recovery to only those portions of the payments made for medical expenses. The parties have entered into a stipulation regarding damages, whereby the State will recover $215,645.30 if it prevails on the statutory construction issue, but only $35,581.47 if Ahlborn prevails. This first figure represents the total amount the parties stipulated the State paid in relation to Ahlborn's care. The parties stipulated that the second figure, which represents 16.5 percent of this total amount, is a fair representation of the percentage of the settlement constituting payment by the tortfeasor for past medical care.

The parties filed cross-motions for summary judgment, and the district court granted the State's motion. The court interpreted the relevant federal statutory provisions to mean that the State may recover from Ahlborn's settlement the sum stipulated as the total amount of benefits provided under the Medicaid program, regardless whether the settlement funds represent payments for the cost of medical services. We review the grant of summary judgment *de novo*, applying the same standard as the district court. *Murphey v. City of Minneapolis*, 358 F.3d 1074, 1077 (8th Cir.2004). We will affirm the grant of summary judgment if there is no genuine issue as

to any material fact and the moving party is entitled to judgment as a matter of law. Fed.R.Civ.P. 56(c); *Shelter Ins. Cos. v. Hildreth*, 255 F.3d 921, 924 (8th Cir.2001).

II.

The Medicaid program was established in 1965 by Title XIX of the Social Security Act ("the Act"), codified at 42 U.S.C. § 1396-1396v. The primary purpose of the program is to provide federal financial assistance to States that elect to reimburse certain costs of medical treatment for needy individuals. *See Harris v. McRae*, 448 U.S. 297, 301, 100 S.Ct. 2671, 65 L.Ed.2d 784 (1980). States voluntarily agree to participate in the program, but must comply with federal requirements once they do so. *Id.* It is often said that Congress wanted Medicaid to be a "payer of last resort, that is, other available resources must be used before Medicaid pays for the care of an individual enrolled in the Medicaid program." S.Rep. No. 99-146, at 312 (1985), *reprinted in* 1986 U.S.C.C.A.N. 42, 279. The sole issue presented by the parties in this case is whether the Arkansas statutory scheme for recovering Medicaid payments comports with the federal statutes governing how state Medicaid recovery programs must operate. The essential disagreement is whether the State may recover from Ahlborn's settlement any amount beyond that stipulated to be expenses for medical care.

Under Arkansas law, applicants for Medicaid benefits "automatically assign" their rights to "any settlement, judgment, or award which may be obtained against any third party to [ADHS] to the full extent of any amount which may be paid by Medicaid for the benefit of the applicant." Ark.Code Ann. § 20-77-307(a). "The assignment

shall be considered a statutory lien on any settlement, judgment, or award received by the recipient from a third party." *Id.* § 20-77-307(c). Further, Arkansas Code Section 20-77-302(a) provides that when a Medicaid recipient brings a claim against a liable third party, "any settlement, judgment, or award obtained is subject to the division's claim for reimbursement of the benefits provided to the recipient under the medical assistance program." Arkansas thus requires recoupment from, and places a lien on, the entirety of third-party payments – not just that portion of third-party payments made for medical care.

Ahlborn argues that the Arkansas scheme conflicts with federal law. She relies on 42 U.S.C. § 1396p(a)(1), which prohibits (with certain exceptions not applicable here) the imposition of a lien "against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan[.]" This provision, sometimes referred to as the "anti-lien statute," generally prevents a State from attaching property of a recipient to reimburse the State for benefits paid under a state Medicaid plan. Under the statute's implementing regulation, "property" is defined as "the homestead and all other personal and real property in which the recipient has a legal interest." 42 C.F.R. § 433.36(b).

The State argues that the Arkansas statutory lien "on any settlement, judgment, or award received by the recipient from a third party" does not conflict with the federal anti-lien statute, because the settlement that Ahlborn received from the tortfeasor is not Ahlborn's property. The State contends that because Ahlborn assigned to the State her right to any settlement as a condition of receiving Medicaid benefits, the settlement remains

property of the tortfeasor until the State is fully reimbursed for all funds expended on Ahlborn's medical care. This appears to be the reasoning adopted by the majorities of two divided state court decisions on which the State relies. *Houghton v. Dep't of Health*, 57 P.3d 1067, 1069 (Utah 2002); *Wilson v. State*, 142 Wash.2d 40, 10 P.3d 1061, 1066 (2000).

We believe that Ahlborn's right to a settlement that may be received from a third party, which the Arkansas statute required her to assign to the State, was Ahlborn's "property." Her unliquidated tort claim, in other words, is a form of "personal . . . property in which the recipient has a legal interest." 42 C.F.R. § 433.36(b). "It is basic property law that a chose in action is personal property," and that "the right to sue for damages is property." *Gregory v. Colvin*, 235 Ark. 1007, 363 S.W.2d 539, 540 (1963). The Arkansas assignment statute, moreover, contemplates that the lien arises *after* Ahlborn receives her settlement from the tortfeasor: "The assignment shall be considered a statutory lien on any settlement, judgment, or award *received by the recipient from a third party.*" Ark.Code Ann. § 20-77-307(c) (emphasis added). Thus, whether the State's assignment and lien act upon Ahlborn's cause of action or the settlement she received from the third-party tortfeasors, we see no basis in the governing federal regulations or the common law of property to conclude that the assignment or lien acted upon something other than Ahlborn's property.

We do not believe, moreover, that the State may circumvent the restrictions of the federal anti-lien statute simply by requiring an applicant for Medicaid benefits to assign property rights to the State before the applicant liquidates the property to a sum certain. If the State could

proceed in that manner, then we do not see what limiting principle would preclude the State from requiring a Medicaid applicant to assign to the State other interests in property – such as future wages, lottery winnings, or real property – in order to reimburse the State for health care expenditures under Medicaid. This sort of broad ranging assignment requirement clearly would conflict with the federal anti-lien statute. The State, at oral argument, disclaimed an ability to require a Medicaid applicant to assign unlimited property interests, and relied instead on a narrower justification for the Arkansas statutory lien on recovery from tortfeasors. The State ultimately asserts that because other federal statutes *require* the State to impose the statutory lien created by Section 20-77-307(c), the Arkansas statute cannot conflict with the federal anti-lien statute.[1]

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[1] The State also argues on brief that Ahlborn's unliquidated cause of action is a "resource" that should be considered in determining whether she is eligible for Medicaid benefits in the first place. *See* 42 U.S.C. §§ 1382, 1382b, 1396p(e)(5). The State complains that Ahlborn should not be allowed to "exclude the value of her tort claim to receive benefits and later shield the same resource to defeat reimbursement." (Appellee Br. at 18). We view this argument as largely a red herring, because the State already determined that Ahlborn was eligible for Medicaid benefits, and her eligibility is not at issue in this lawsuit.

In any event, the State's effort to equate "resources" available to an applicant in the eligibility determination with "property" that is shielded from state recovery efforts by the anti-lien statute is not supported by federal or state law. "Resources" is defined by the federal regulation that implements 42 U.S.C. § 1382b as "cash or other liquid assets or any real or personal property that an individual . . . owns and could convert to cash to be used for his or her support and maintenance." 20 C.F.R. § 416.1201(a). An unliquidated personal injury cause of action cannot be sold or assigned, *Mallory v. Hartsfield, Almand & Grisham, LLP*, 350 Ark. 304, 86 S.W.3d 863, 866 (2002), so at the time she applied for benefits, Ahlborn lacked the power to convert her cause

(Continued on following page)

The federal statutes in question provide that a state Medicaid plan must provide that the State acquires the rights of a Medicaid beneficiary to certain payments by third parties, 42 U.S.C. § 1396a(a)(25)(H), and require that a beneficiary assign to the State certain rights to payment from third parties, 42 U.S.C. § 1396k(a)(1). The first statute provides:

> A State plan for medical assistance must –
>
> . . .
>
> (25) provide –
>
> . . .
>
> (H) that to the extent that payment has been made under the State plan for medical assistance in any case where *a third party has a legal liability to make payment for such assistance*, the State has in effect laws under which, to the extent that payment has been made under the State plan for medical assistance for health care items or services furnished to an individual, the State is considered to have acquired the rights of such individual *to payment by any other party for such health care items or services.*

42 U.S.C. § 1396a(a)(25)(H) (emphasis added).

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of action to cash for support and maintenance. The Arkansas administrative code, moreover, defines "resource" as any real or personal property "available to an individual to meet his needs," and specifies that "[o]nly those resources currently available, or for which the individual has the legal ability to make available, will be considered." Code of Ark. Rules 016.20.001, Medical Services Policy Manual § 11301 (June 1, 2002). Thus, although the cause of action was "property," 42 C.F.R. § 433.36(b), it was not a "resource." *Cf. Smith v. Ariz. Long Term Care Sys.*, 207 Ariz. 217, 84 P.3d 482, 487 (Ct.App.2004).

The second provision states:

> (a) For the purpose of assisting in the collection of medical support payments . . . a State plan for medical assistance shall –
>
> (1) provide that, as a condition of eligibility for medical assistance . . . to an individual . . . the individual is required –
>
> (A) to assign the State any rights . . . *to payment for medical care from any third party*;
>
> . . .
>
> (C) to cooperate with the State in identifying, and providing information to assist the State in pursuing, any third party *who may be liable to pay for care and services* available under the plan
>
> . . . .

42 U.S.C. § 1396k(a)(1)(A) (emphasis added).

We believe a straightforward interpretation of the text of these statutes demonstrates that the federal statutory scheme requires only that the State recover payments from third parties to the extent of their legal liability to compensate the beneficiary *for medical care and services* incurred by the beneficiary. Under § 1396a(a)(25)(H), a state Medicaid plan must include provisions specifying that, when the State provides medical benefits to an applicant, "the State is considered to have acquired the rights of such individual to *payment by any other party for such health care items or services.*" (emphasis added). This acquisition of rights occurs only in cases where "a third party has a legal liability to make payment for [medical] assistance." *Id.* Section 1396k(a)(1)(A) similarly requires that an applicant assign to the State her right "to *payment*

for medical care from any third party." (emphasis added). Both statutes are thus limited to rights to third-party payments made to compensate for medical care.

Taking the three federal statutes together, we agree with the Supreme Court of Minnesota that the plain meaning of each achieves a harmonious statutory scheme:

> The anti-lien provision protects the personal property of a medical assistant recipient – here, [the plaintiff's] cause of action – from a state's effort to recover for medical expenses. The assignment transfers to the state the recipient's right to recover medical expenses, and therefore the ability to pursue directly potentially liable third parties for medical assistance expenses paid.
>
> The anti-lien provision protects all of a recipient's nonassigned rights to recover. The recovery provision, on the other hand, requires that the state pursue the third parties for medical expenses paid by the state, and the state does so under the assignment.

Martin ex rel. Hoff v. City of Rochester, 642 N.W.2d 1, 13 (Minn.2002). Where, as here, the recipient pursues the third party directly for medical expenses, the recovery provision also allows the State to establish a lien to the extent that a settlement or award constitutes payment by the third party for medical expenses incurred by the recipient.

The State nonetheless urges us to adopt the view espoused by the federal Health Care Financing Administration, and upheld by the Departmental Appeals Board of the Department of Health and Human Services ("HHS") in two adjudications during the 1990s. *See Calif. Dep't of Health Servs.*, D.A.B. No. 1504, 1995 WL 66334 (HHS Jan. 5, 1995) ("*Calif.Dep't*"); *Wash. State Dep't of Soc. and Health Servs.*, D.A.B. No. 1561, 1996 WL 157123 (HHS Feb. 7, 1996) ("*Wash. State Dep't*"). These adjudications conclude that the federal government can require States to attempt to recover from third-party payments beyond those made for medical care.[2]

The parties dispute whether the HHS decisions are entitled to deference under the doctrine of *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842-43, 104 S.Ct. 2778, 81 L.Ed.2d 694 (1984), as an agency's interpretation of an ambiguous federal statute that it is charged with administering. While we agree that an agency's formal adjudication may be entitled to deference in an appropriate case, *cf. Christensen v. Harris County*, 529 U.S. 576, 587, 120 S.Ct. 1655, 146 L.Ed.2d 621 (2000), the principles of deference apply only when a statute is ambiguous and the agency advances a reasonable interpretation of the statute. In this case, we reject the agency's interpretation as inconsistent with the plain language of the statute.

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[2] During the 1990s, some States concluded that a policy of attempting to recover from Medicaid recipients all third-party liability settlements and payments was not the best method to conserve public funds. The State of California, for example, concluded that allowing victims to share in awards "created an incentive to seek out and pursue liable third parties, thereby maximizing pursuit and shifting initial costs from California to the victim." D.A.B. No. 1504, at 13. In decisions involving the California and Washington state Medicaid programs, however, HHS disallowed federal financial participation on the ground that anything less than 100 percent state recovery of third-party liability settlements and payments was inconsistent with federal law.

The HHS adjudications cite three reasons why States can be required to attempt to recover funds from those third-party payments for damages other than the cost of medical care and services. First, HHS reasoned that "[i]n cases where a third party has caused the need for medical care and is liable for its payment, the Act looks to that third party to reimburse the public." *Wash. State Dep't*, D.A.B. No. 1561, at 8; *Calif. Dep't*, D.A.B. No. 1504, at 10. While we agree that the Act looks to third parties to reimburse taxpayer funds, HHS supports its view by noting that States are required under 42 U.S.C. § 1396a(a)(25)(B) to "seek reimbursement for such assistance to the extent of such legal liability." *Wash. State Dep't*, D.A.B. No. 1561, at 8; *Calif. Dep't*, D.A.B. No. 1504, at 10. The phrase "such legal liability," however, refers back to "legal liability" in § 1396a(a)(25)(A), which makes clear that this is "the legal liability of third parties . . . *to pay for care and services available under the plan*[.]" Where, as here, the State seeks reimbursement for amounts payable to the Medicaid recipient for other damages such as lost wages, the text of the Act cited by HHS does not authorize recovery.

Second, HHS concluded that it is reasonable for the government to condition the availability of Medicaid funds on a recipient's agreement to reimburse Medicaid to the extent of a third party's liability. Therefore, according to HHS, "Medicaid has superior status to the recipient in relation to the tortfeasor to recover costs Medicaid incurred on behalf of the recipient on the condition that it would be reimbursed if there was a liable third party from whom a recovery was collected." *Wash. State Dep't*, D.A.B. No. 1561, at 8; *Calif. Dep't*, D.A.B. No. 1504, at 11. While the condition described may well be reasonable as a

matter of public policy, the HHS interpretation contradicts the express statutory language. Recipients are not required under federal law to reimburse Medicaid "to the extent of the third party's liability." *Id.* Rather, recipients are only required to assign their rights to third-party payments for medical care. 42 U.S.C. §§ 1396a(a)(25)(H), 1396k(a)(1)(A). We therefore reject HHS's second reason for requiring States to recover from third-party payments portions not designated for medical care.

Finally, HHS relied on a concern that if States were limited to recovering payments from third parties for medical care and services, then recipients could prevent state recovery by intentionally manipulating the amounts paid for various claims. *Wash. State Dep't*, D.A.B. No. 1561, at 9; *Calif. Dep't*, D.A.B. No. 1504, at 11. For example, during settlement negotiations, a Medicaid recipient could agree with a third party to reduce the amount paid for medical care, but increase the amount paid for pain and suffering. Or a recipient might attempt to recover only for damages other than past medical expenses, and thus assert that a lump-sum payment does not include funds for such expenses.

The federal statutes, of course, do not leave the States without a remedy in this situation: Through the assignment provision, a State has legal authority to pursue directly the third-party tortfeasor for medical expenses incurred by the recipient. And we do not foreclose the possibility that manipulation of settlement amounts might, in an appropriate case, provide the basis for a State to recover funds received by a Medicaid beneficiary from a third-party tortfeasor, even though they are not technically denominated payments for medical care and services. In such a circumstance, however, the recovery might be

permissible because the third-party payment is properly recharacterized *as a payment for medical expenses,* despite a different label applied by the parties, not because the federal statutes authorize the State to recover *all* payments from third parties up to the amount of funds expended by the state Medicaid program. In this case, there is no dispute about which portion of Ahlborn's settlement represents payment for medical care, so the potential for manipulation of settlements provides no basis for the State to capture funds received by Ahlborn to compensate for damages other than the costs of medical care.

In the end, we are left with a federal statutory scheme that clearly requires Ahlborn to assign her rights to recover from third parties for the costs of medical care and services incurred as a result of their tortious conduct, but protects all of Ahlborn's nonassigned property from recovery by the State through the anti-lien statute. The Arkansas statutes requiring Ahlborn to assign her entire cause of action against the third-party tortfeasors, and establishing a statutory lien on settlement proceeds for matters other than medical care and services, conflict with and frustrate this federal scheme. *See Hines v. Davidowitz,* 312 U.S. 52, 67, 61 S.Ct. 399, 85 L.Ed. 581 (1941). Accordingly, we conclude that Ahlborn prevails on the question of statutory construction presented by the parties on this appeal, and that the Arkansas assignment and recovery statutes are preempted to the extent that they require Ahlborn to assign her rights to recover third-party liability payments for matters other than the cost of her medical care and services.

* * *

The judgment of the district court is reversed, and the case is remanded with directions to enter judgment for the State in the amount of $35,581.47.

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280 F.Supp.2d 881

United States District Court,
E.D. Arkansas,
Western Division.
Heidi AHLBORN, Plaintiff,
v.
ARKANSAS DEPARTMENT OF HUMAN SERVICES; Kurt Knickrehm, Director of the Arkansas Department of Human Services; Wayne Olive, Director of the Third Party Liability Unit; Roy Jeffus, Interim Director, Division of Medical Services of the Arkansas Department of Human Services, Defendants.
No. 4:02-CV-00607 GTE.

Aug. 22, 2003.

H. David Blair, Blair & Stroud, Phillip B. Farris, Gregg & Harris, Batesville, AR, for plaintiff.

Richard B. Dahlgren, Arkansas Department of Human Services, Office of Chief Counsel, Little Rock, AR, for defendants.

ORDER GRANTING SUMMARY JUDGMENT

EISELE, District Judge.

This matter is before the Court on cross motions for summary judgment. The parties agree that the issue in this case – the extent to which Defendants are entitled to recoup Medicaid benefits paid on Plaintiff's behalf from settlement proceeds received by Plaintiff from her personal injury lawsuit – is a statutory construction issue for the Court. The parties have entered into a stipulation agreeing to the amount of reimbursement, depending on

which party prevails, making it unnecessary for the Court to hear evidence regarding damages or make any damage determinations in this case. (*See* Stipulation of Parties, docket entry 6).

The issue has been fully briefed. On August 20, 2003, the Court heard oral argument on the motions. After considering the written submissions of the parties and their oral presentations, the Court finds that Defendants are entitled to judgment as a matter of law.

I. *Facts Without Controversy*

Heidi Ahlborn suffered severe, permanently disabling injuries in a motor vehicle accident on January 2, 1996. Ms. Ahlborn filed suit against various individual and entity defendants alleged to be responsible for her injuries. Ms. Ahlborn sustained injuries and losses from the January 2, 1996 motor vehicle accident which would have given rise to the following elements of damage under Arkansas law:

(a) Permanent injury;

(b) Past and future medical expenses;

(c) Past and future pain, suffering and mental anguish;

(d) Past loss of earnings and working time;

(e) Permanent impairment of ability to earn in the future.

In 2002, a compromise settlement was reached with the alleged tort-feasors pursuant to which the sum of $550,000

was paid to Ms. Ahlborn.[1] The settlement amount represented a compromise of plaintiff's tort claim. No effort was made to allocate by agreement or adjudication the proceeds of the compromise settlement among the elements of damage arising under Arkansas law.

Following her accident, Plaintiff applied for and was granted Medicaid benefits to pay for her extensive medical treatment. The Medicaid program in Arkansas is funded with federal and state dollars and is administered by the Defendant Arkansas Department of Human Services ("ADHS"). ADHS provided Medicaid benefits to or on behalf of Plaintiff for medical care.

The Defendant Director of ADHS asserted a claim or lien pursuant to Ark.Code Ann. § 20-77-310, *et seq.*, in the amount of $219,156.78 against any settlement proceeds recovered by Plaintiff. That sum is being held by Plaintiffs' attorneys in a trust account pending resolution of this lawsuit, which was initiated on September 30, 2002, by Plaintiff Heidi Ahlborn. The Defendants are all state entities or officials with responsibilities related to the administration and enforcement of liens or rights by reason of payments made to or on behalf of Medicaid beneficiaries.[2]

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[1] Of that amount, $25,000 was paid by Plaintiff's underinsured motorist coverage.

[2] The amount of money paid on Ms. Alhborn's behalf as Medicaid benefits varies slightly in the pleadings, as she was still receiving benefits at the time of the settlement of her tort claims and the filing of this action. It is undisputed that Defendants had paid $216,645.20 in Medicaid proceeds at that time of the settlement of the third party action. However, Defendants are only seeking reimbursement in the sum of $215,645.30, if they prevail upon the statutory construction issue. The slight discrepancy in the numbers reflects adjustments made

(Continued on following page)

II. *Discussion*

The parties dispute the extent of Defendants' right of reimbursement from the settlement proceeds. Plaintiff contends the Defendants' Medicaid recovery is limited to that portion of the settlement proceeds which fairly represents the past medical expense component of her recovery. Defendants contend that they are entitled to a full reimbursement of all Medicaid funds paid on Plaintiff's behalf. The parties have stipulated to the respective damage amounts – if Plaintiff prevails, Defendants shall recover $35,581.47; if Defendants prevail, Defendants shall recover $215,645.30.

MEDICAID PROGRAM

The federal Medicaid statutes were enacted in 1965 as Title XIX of the Social Security Act, a publicly funded program to provide medical care to those lacking the resources to obtain essential medical services. 42 U.S.C.A. §§ 1396-1396v; *Norwest Bank of N.D., N.A v. Doth*, 159 F.3d 328, 331 (8th Cir.1998). Medicaid, which was intended to be the payor of last resort, is jointly funded by the federal and state governments. 42 C.F.R. § 430.0.

The federal government provides financial assistance to enable " . . . each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of [individuals], whose income and resources are insufficient to meet the costs of necessary medical services . . . " Participation in the program is voluntary, but

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to eliminate Medicaid payments made on Ms. Ahlborn's behalf for medical care unrelated to injuries sustained in the car accident.

once a state elects to participate, it must comply with the requirements set forth in the Medicaid Act and in regulations promulgated by the United States Secretary of Health and Human Services ("the Secretary") through the Centers for Medicare & Medicaid Services ("CMS") which administers Medicaid.[3] *See* 42 C.F.R. § 447.302. Participating states must submit for CMS's approval a state Medicaid plan. *See generally*, 42 U.S.C.A. § 1396a(a).

Arkansas participates in the federal Medicaid program and has designated Defendant ADHS as the single state agency responsible for administrating the State plan. *See* Ark.Code Ann. § 20-76-201(1). Arkansas' Medicaid plan, which the Secretary approved as consistent with the federal statute and implementing regulations, is codified at Ark.Code Ann. § 20-77-301 *et seq*.

Federal law requires that participating states include in their Medicaid plan the requirement that recipients of Medicaid funds assign to the state the right to receive payments for medical expenses from third parties liable for payment of those expenses. 42 U.S.C. § 1396k. The statute provides in pertinent part:

> (a) For the purpose of assisting in the collection of medical support payments and other payments for medical care owed to recipients of medical assistance under the State plan approved under this subchapter, a State plan for medical assistance shall –

[3] The federal agency responsible for administering Medicaid was formerly known as the Health Care Financing Administration, and frequently referred to as HCFA.

> (1) provide that, as a condition of eligibility for medical assistance under the State plan . . . the individual is required –
>
> (A) to assign to the States any rights, of the individual . . . to payment for medical care from any third party;
>
> . . . .
>
> (b) Such part of any amount collected by the State under an assignment made under the provisions of this section shall be retained by the State as is necessary to reimburse it for medical assistance payments made on behalf of an individual with respect to whom such assignment was executed (with appropriate reimbursement of the Federal Government to the extent of its participation in the financing of such medical assistance), and the remainder of such amount collected shall be paid to such individual.

Id.

In compliance with the federal requirement, Arkansas' plan provides ADHS with an automatic assignment of a Medicaid recipient's right of recovery from any settlement. The Arkansas statute reads:

> (a) As a condition of eligibility, every Medicaid applicant shall automatically assign his or her right to any settlement, judgment, or award which may be obtained against any third party to the Department of Human Services to the full extent of any amount which may be paid by Medicaid for the benefit of the applicant.
>
> (b) The application for Medicaid benefits shall, in itself, constitute an assignment by operation of law.

> (c) The assignment shall be considered a statutory lien on any settlement, judgment, or award received by the recipient from a third party.

Ark.Code Ann. § 20-77-307.

Plaintiff argues the Arkansas statute assigns away more rights than required by 42 U.S.C. § 1396k(a), in conflict with a second provision of the federal Medicaid statute, 42 U.S.C. § 1396p(a)(1). This provision, often referred to as the "anti-lien provision", provides that

> [n]o lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan . . . "[4]

Defendants contend that personal injury settlements assigned to the State in this context are not property of the individual beneficiaries of Medicaid assistance within the meaning of 42 U.S.C. § 1396p(a)(1). Their argument is based upon a reading of the "anti-lien" provision which makes it inapplicable to a Medicaid recipient's cause of action assigned away in exchange for Medicaid eligibility. Under this construction, although an injured party has a property right in her cause of action against a third party, the right is disposed of to the extent of medical expenses paid by Medicaid when she agrees, by virtue of the assignment, to apply *all* proceeds from a liable third-party to the state to the full extent of Medicaid benefits paid on her behalf. Thus, Defendants reason, a Medicaid recipient has no property interest in settlement funds from the third-party

[4] The statute contains two exceptions to the lien prohibition, but neither is applicable here.

until *after* the State and federal government have been reimbursed for their Medicaid expenditures.

Plaintiff's argument centers on the extent of the assignment. Plaintiff concedes that ADHS may force her to assign her tort claims to the extent of any amounts payable for medical expenses. She objects, however, to an assignment of her entire cause of action, contending that the federal scheme prohibits ADHS from attaching anything more than her claim for health care items or services from a third-party.

In support of her contention, Plaintiff relies on 42 U.S.C. § 1396a(a)(25)(H), which provides that:

> to the extent that payment has been made under the State plan for medical assistance in any case where a third party has a legal liability to make payment for such assistance, the State has in effect laws under which, *to the extent that payment has been made under the State plan for medical assistance for health care items or services furnished to an individual, the State is considered to have acquired the rights of such individual to payment by any other party for such health care items or services*; . . .

(emphasis added).

The Plaintiff reasons that the State is only entitled to a statutory assignment of a Medicaid recipient's rights to third-party payments for "health care items or services," not for the entire cause of action, which may include damages for lost wages, pain and suffering and other non-healthcare related items. Construing the statute in such a fashion, Plaintiff argues, harmonizes the state procedure with 42 U.S.C. § 1396a(a)(25)(H) and § 1396p(a)(1). Construing the

statute otherwise, Plaintiff contends, permits the State to place a lien on Plaintiff's property in violation of the federal Medicaid Act's anti-lien provision.

ANALYSIS OF APPLICABLE LAW

In support of its position, Plaintiff relies upon the Minnesota Supreme Court's decision in *Martin v. City of Rochester*, 642 N.W.2d 1 (Minn.2002), *cert. denied*, 539 U.S. 957, 123 S.Ct. 2668, 156 L.Ed.2d 655, 71 U.S.L.W. 3116 (2003). This is the only decision, to the Court's knowledge, adopting the position advocated by Plaintiff. The *Martin* decision found Minnesota's state Medicaid subrogation provision[5] to be conflict preempted by the federal anti-lien provision to the extent that it permitted the state, through its assignment provision, to obtain anything more from a Medicaid recipient than the recipient's "rights to payment for medical care from third

[5] Minnesota's statutory assignment provision reads in pertinent part:

> To be eligible for medical assistance a person must have applied or must agree to apply all proceeds received or receivable by the person . . . from any third person liable for the costs of medical care for the person . . . The state agency shall require from any applicant or recipient of medical assistance the assignment of any rights to medical support and third party payments . . . . By signing an application for medical assistance, a person assigns to the department of human services all rights the person may have to medical support or payments for medical expenses from any other person or entity on their own or their dependent's behalf and agrees to cooperate with the state in . . . obtaining third party payments.

Minn.Stat. § 256B.056, subd. 6.

parties liable for the injuries that necessitated medical assistance." *Martin*, 642 N.W.2d at 18.

Central to the decision in *Martin* is the court's determination that §§ 1396k and 1396a(a)(25)(H) of the federal Medicaid statute limit the required assignment of rights to payment for medical care only. *Id.*, at 12-13. Thus, "a state's right to recover from third parties is specifically limited under federal law to payment *for health care items or services only.*" Starting with this premise, the *Martin* court concludes that the right assigned to states is likewise limited. *Id.*, at 13. The court summarizes its analysis as follows:

> The foregoing analysis convinces us that there is no need to engage in arduous or belabored statutory construction to harmonize the three federal statutes. Taking notice of the plain meaning of each is sufficient to achieve harmony.
>
> The anti-lien provision [§ 1398k)] protects the personal property of a medical assistance recipient – here, [Plaintiff's cause of action] – from a state's effort to recover for medical expenses. The assignment transfers to the state the recipient's right to recover medical expenses, and therefore the ability to pursue directly potentially liable third parties for medical assistance paid. The anti-lien provision protects all of a recipient's nonassigned rights to recover. The recovery provision [§ 1396a(a)(25)(H)] on the other hand, requires that the state pursue the third parties for medical expenses paid by the state, and the state does so under the assignment. The result is that the anti-lien provision operates in harmony with other federal Medicaid provisions and gives effect to all of the provisions.

Id., at 13.

The dissent in *Martin* concludes otherwise.

Focusing on the scope of the initial assignment, the dissent concludes that a state's assignment provision (requiring a recipient to apply or to agree to apply her settlement rights to the full extent of any Medicaid benefits paid on her behalf) poses no conflict with the federal anti-lien provision. *Martin*, 642 N.W.2d at 28-29 (dissent). The dissent in *Martin* and the highest courts of Utah and Washington reconcile any apparent conflict with § 1396p's anti-lien provision by finding that the anti-lien provision drops out of the analysis once a Medicaid recipient assigns his cause of action because the recipient no longer has any interest in the property (his or her cause of action against third parties) to the extent of the state's expenditures. *See Wallace v. Estate of Jackson*, 972 P.2d 446 (Utah 1998), *cert. denied, McNeil v. Utah, Medicaid Section*, 528 U.S. 810, 120 S.Ct. 42, 145 L.Ed.2d 38 (1999); and *Wilson v. State*, 142 Wash.2d 40, 10 P.3d 1061 (2000).

In *Wallace*, the Utah Supreme Court determined that a third party's payments do not legally become the property of the recipient until after settlement " 'because third party settlement proceeds have been specified by the recipient as belonging to the State Medicaid Agency as a precondition of the recipient's eligibility.' " *Id.*, 972 P.2d at 448 (quoting state's brief). Similarly, the Washington Supreme Court held in *Wilson* that all settlement proceeds belonged to the state because they were assigned as such. The Court found that "due to the lien being placed on the settlement prior to it becoming the property of the Medicaid recipient, the [anti-lien provision] is irrelevant." *Wilson*, 10 P.3d at 1065 n. 2. The court in *Wilson* specifically rejected limiting the permissible scope of a state's recovery from third-parties, finding that, "the state is not

limited to recovery from only that portion of the settlement specifically allocated to medical expenses. The federal statute states recovery is to the extent of payment made by the state for health care items or services." *Id.*, 10 P.3d at 1066.

The Eighth Circuit in *Norwest Bank of N.D., N.A. v. Doth*, 159 F.3d 328, 333-34 (8th Cir.1998), construing Minnesota's Medicaid statutes, held that the state could satisfy its lien from settlement proceeds before the funds were placed in a supplemental needs trust for the recipient. The *Doth* Court specifically noted that it was not passing "on the question of whether the lien [could] be satisfied out of the entire amount of the personal injury award or settlement, or only that portion of the settlement attributable to past medical expenses." *Id.*, 159 F.3d at 334.

The Secretary has consistently adopted the position urged by Defendants, taking the position that States must require, as a condition of eligibility, that recipients assign to the State their right to recover from third parties and that, from any such recovery, the State must recover the full amount of benefits paid on behalf of the recipient. *See* Defendants' Exh. 3, HCFA letter to State Agencies received June 13, 1988; Exh. 21 and 22, HCFA memorandums.

The Secretary has not hesitated to enforce its position against participating States, should they fail to recover from a Medicaid recipient subsequently acquired settlement proceeds up to the full amount of Medicaid benefits paid on the recipient's behalf. In such cases, to the extent a State allowed a Medicaid recipient to retain settlement proceeds without fully reimbursing the State, HCFA recoups from the State the federal share of such Medicaid

benefits. (*See* Exhibits 24 and 25 to Defendants' motion, Department of Health and Human Services Department Appeals Board decisions affirming the Secretary's decision to impose financial penalties on California and Washington for accepting less than a full recovery of Medicaid benefits paid).

The Court finds that the Secretary's position is entitled to due consideration. Cf. *United States v. Mead Corp.*, 533 U.S. 218, 121 S.Ct. 2164, 150 L.Ed.2d 292 (2001); *Thomas Jefferson Univ. v. Shalala*, 512 U.S. 504, 512, 114 S.Ct. 2381, 129 L.Ed.2d 405 (1994) (reliance on Secretary's "significant expertise" particularly appropriate in the context of "a complex and highly technical regulatory program" (internal quotation marks omitted)); *Schweiker v. Gray Panthers*, 453 U.S. 34, 43-44, 101 S.Ct. 2633, 69 L.Ed.2d 460 (1981) (Secretary granted "exceptionally broad authority" under the Medicaid statute).

If, at the time Plaintiff applied for medical benefits, her lawsuit – which Plaintiff agrees is a property right – had been realized or reduced to a sum certain, she would have been forced to expend that resource before she would have qualified for Medicaid benefits. Thus, this is not – as Plaintiff argues – a situation in which Plaintiff's eligibility for Medicaid benefits is being determined retroactively after her tort claim is liquidated. Further, the Court disagrees with Plaintiff's contention that an unliquidated tort claim would not constitute a "resource" for purposes of determining an applicant's eligibility for Medicaid benefits.

In determining whether an applicant is eligible to receive Medicaid, Congress instructed states to consider an individual's income and resources. 42 U.S.C. § 1382.

Congress does not define "resources" affirmatively, but excludes from the definition of "resources" certain categories of property. 42 U.S.C. § 1382b. There is nothing in the language of the Act to exclude from the definition of "resources" an unliquidated tort claim against a third-party. Given the approach of the statute, which defines by exclusion, the Court finds that a Medicaid applicant's unliquidated tort claim against a third-party is both a "resource" and "property" for purposes of the Medicaid Act. Thus, there is nothing incongruent about requiring an applicant, as a condition of Medicaid eligibility, to assign to the State his entire "rights to payment from third parties." 42 U.S.C. § 1396k.

As stated by the Utah Supreme Court:

> Placing a lien against third party settlement proceeds does not result in a "lien against the property of an individual prior to his death on account of medical assistance paid or to be paid on his behalf" [which the anti-lien provision prohibits] because third party settlement proceeds have been specified by the recipient as belonging to the State Medicaid Agency as a precondition of the recipient's eligibility.

Wallace, 972 P.2d at 448 (referencing the State's brief).

Section 1396a(a)(25), which the Plaintiff construes as limiting Arkansas' right of assignment, is harmonized with the remainder of the Medicaid statute by a broader reading. The Medicaid statute requires States to ascertain the "legal liability" of third parties "to pay for care and services" rendered under the Medicaid program, 42 U.S.C. § 1396a(a)(25)(A), and, to pursue recovery to the full "*extent of such legal liability*," 42 U.S.C. § 1396a(a)(25)(B) (emphasis added). Full effect to the statute as a whole is

supported by an interpretation of the statutory provisions that does not limit States to the compromise value assigned to the medical expense component of the assigned claim during settlement negotiations. *See also* 42 U.S.C. § 1396k(a)(1)(A)(assigning right to "payment for medical care"); *Wilson*, 10 P.3d at 1066 ("[T]he assignment is for the right of payment from the third party, not solely the right to pursue a cause of action against the third party.").

Although the statutory language in question is far from a model of clarity, when the Court considers the statute as a whole, the Secretary's position on the issue, and the legislative history of the Medicaid statute,[6] it concludes that the Defendants have the better argument. The Medicaid statute is intended to vest States with the right to recover the full payment of medical expenses by a third party liable for causing the injuries which triggered the need for medical care.

As a public policy matter, the majority approach avoids the problem of determining what portion of a settlement is fairly attributable to payment for medical expenses. In this case, the parties have reached a stipulation on the apportionment issue. In general, however, adopting the approach advocated by Plaintiff would encourage manipulation of the allocation of settlement amounts. It would also place upon States the additional burden of proving up the past medical expense component of a compromise settlement or challenging the allocation

[6] Congress specifically "intended [Medicaid] to be the payer of last resort, that is, other available resources must be used before Medicaid pays for the care of an individual enrolled in the Medicaid program." S.Rep. No. 99-146, at 312 (1986), *reprinted in* 1986 U.S.C.C.A.N. 42, 279.

made by others with no interest in placing an appropriate value on that component of recovery. Conversely, the approach this Court adopts, which has been adopted by all but one court confronted with the issue, "prevents manipulation of tort awards by recipients who seek to prevent the public from being reimbursed for the funds it has advanced for their medical care." *Martin*, 642 N.W.2d at 22 (internal quotes and citations omitted).

CONCLUSION

For the reasons discussed herein,

IT IS THEREFORE ORDERED that Plaintiff's Cross-Motion for Summary Judgment, Docket No. 14, be and it is hereby, DENIED.

IT IS FURTHER ORDERED that Defendant's Motion for Summary Judgment, Docket No. 7, be and it is hereby, GRANTED.

Judgment will be entered separately.

JUDGMENT

Pursuant to the Order filed in this matter this date granting summary judgment in favor of the Defendants, it is Considered, Ordered, and Adjudged that the Complaint in this matter be, and it hereby is, dismissed in its entirety.

42 U.S.C. § 1382b. Resources.

(a) Exclusions from Resources – In determining the resources of an individual (and his eligible spouse, if any) there shall be excluded –

(1) the home (including the land that appertains thereto);

(2)(A) household goods, personal effects, and an automobile, to the extent that their total value does not exceed such amount as the Commissioner of Social Security determines to be reasonable; and

(B) the value of any burial space or agreement (including any interest accumulated thereon) representing the purchase of a burial space (subject to such limits as to size or value as the Commissioner of Social Security may by regulation prescribe) held for the purpose of providing a place for the burial of the individual, his spouse, or any other member of his immediate family;

(3) other property which is so essential to the means of self-support of such individual (and such spouse) as to warrant its exclusion, as determined in accordance with and subject to limitations prescribed by the Commissioner of Social Security, except that the Commissioner of Social Security shall not establish a limitation on property (including the tools of a tradesperson and the machinery and livestock of a farmer) that is used in a trade or business or by such individual as an employee;

(4) such resources of an individual who is blind or disabled and who has a plan for achieving self-support approved by the Commissioner of Social Security, as may be necessary for the fulfillment of such plan;

(5) in the case of Natives of Alaska, shares of stock held in a Regional or a Village Corporation, during the period of twenty years in which such stock is inalienable, as provided in section 1606(h) and section 1607(c) of title 43;

(6) assistance referred to in section 1382a(b)(11) of this title for the 9-month period beginning on the date such funds are received (or for such longer period as the Commissioner of Social Security shall by regulations prescribe in cases where good cause is shown by the individual concerned for extending such period); and, for purposes of this paragraph, the term "assistance" includes interest thereon which is excluded from income under section 1382a(b) (12) of this title;

(7) any amount received from the United States which is attributable to underpayments of benefits due for one or more prior months, under this subchapter or subchapter II of this chapter, to such individual (or spouse) or to any other person whose income is deemed to be included in such individual's (or spouse's) income for purposes of this subchapter; but the application of this paragraph in the case of any such individual (and eligible spouse if any), with respect to any amount so received from the United States, shall be limited to the first 9 months following the month in which such amount is received, and written notice of this limitation shall be given to the recipient concurrently with the payment of such amount;

(8) the value of assistance referred to in section 1382a(b) (14) of this title, paid with respect to the dwelling unit occupied by such individual (or such individual and spouse);

(9) for the 9-month period beginning after the month in which received, any amount received by such individual (or such spouse) from a fund established by a State to aid victims of crime, to the extent that such individual (or such spouse) demonstrates that such amount was paid as compensation for expenses incurred or losses suffered as a result of a crime;

(10) for the 9-month period beginning after the month in which received, relocation assistance provided by a State or local government to such individual (or such spouse), comparable to assistance provided under title II of the Uniform Relocation Assistance and Real Property Acquisitions Policies Act of 1970 which is subject to the treatment required by section 216 of such Act (*42 U.S.C. § 4638*);

(11) for the 9-month period beginning after the month in which received –

(A) notwithstanding section 203 of the Economic Growth and Tax Relief Reconciliation Act of 2001, any refund of Federal income taxes made to such individual (or such spouse) under section *24* of the Internal Revenue Code of 1986 (relating to child tax credit) by reason of subsection (d) thereof; and

(B) any refund of Federal income taxes made to such individual (or such spouse) by reason of section *32* of the Internal Revenue Code of 1986 (relating to earned income tax credit), and any payment made to such individual (or such spouse) by an employer under section 3507 of such Code (relating to advance payment of earned income credit);

(12) any account, including accrued interest or other earnings thereon, established and maintained in accordance with section 1383(a)(2)(F) of this title;

(13) any gift to, or for the benefit of, an individual who has not attained 18 years of age and who has a life-threatening condition, from an organization described in section 501(c)(3) of the Internal Revenue Code of 1986 which is exempt from taxation under section 501(a) of such Code –

(A) in the case of an in-kind gift, if the gift is not converted to cash; or

(B) in the case of a cash gift, only to the extent that the total amount excluded from the resources of the individual pursuant to this paragraph in the calendar year in which the gift is made does not exceed $2,000;

(14) for the 9-month period beginning after the month in which received, any amount received by such individual (or spouse) or any other person whose income is deemed to be included in such individual's (or spouse's) income for purposes of this title as restitution for benefits under this title, title II, or title VIII that a representative payee of such individual (or spouse) or such other person under section 205(j), 807, or 1631(a)(2) has misused; and

(15) for the 9-month period beginning after the month in which received, any grant, scholarship, fellowship, or gift (or portion of a gift) used to pay the cost of tuition and fees at any educational (including technical or vocational education) institution.

In determining the resources of an individual (or eligible spouse) an insurance policy shall be taken into account only to the extent of its cash surrender value;

except that if the total face value of all life insurance policies on any person is $1,500 or less, no part of the value of any such policy shall be taken into account.

* * *

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42 C.F.R. § 430.0 Program description.

Title XIX of the Social Security Act, enacted in 1965, authorizes Federal grants to States for medical assistance to low-income persons who are age 65 or over, blind, disabled, or members of families with dependent children or qualified pregnant women or children. The program is jointly financed by the Federal and state governments and administered by States. Within broad Federal rules, each State decides eligible groups, types and range of services, payment levels for services, and administrative and operating procedures. Payments for services are made directly by the State to the individuals or entities that furnish the services.

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42 C.F.R. § 430.35 Withholding of payment for failure to comply with Federal requirements.

(a) Basis for withholding. CMS withholds payments to the State, in whole or in part, only if, after giving the agency reasonable notice and opportunity for a hearing in accordance with subpart D of this part, the Administrator finds

(1) That the plan no longer complies with the provisions of section 1902 of the Act; or

(2) That in the administration of the plan there is failure to comply substantially with any of those provisions.

* * *

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42 C.F.R. § 433.140 FFP and repayment of Federal share.

(a) FFP is not available in Medicaid payments if

(1) The agency failed to fulfill the requirements of §§ 433.138 and 433.139 with regard to establishing liability and seeking reimbursement from a third party;

* * *

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42 C.F.R. § 447.302 State plan requirements.

A State plan must provide that the requirements of this subpart are met.

***Ark. Code Ann. § 20-76-201.* Department of Human Services – Powers and duties.**

The Department of Human Services shall:

(1) Administer all forms of public assistance, supervise agencies and institutions caring for dependent or mentally or physically disabled or aged adults, and administer other welfare activities or services that may be vested in it;

* * *

Ark. Code Ann. § 20-77-301. Action by Department of Human Services.

(a) When medical assistance benefits are provided or will be provided to a medical assistance recipient because of injury, disease, or disability for which another person is liable, the appropriate division of the Department of Human Services shall have a right to recover from the person the cost of benefits so provided. The department may, to enforce the right, institute and prosecute legal proceedings against the third person who may be liable.

(b) No action taken on behalf of the division pursuant to this section or any judgment rendered in the action shall be a bar to any action upon the claim or cause of action of the recipient, his or her guardian, personal representative, estate, or survivors against the third person who may be liable for the injury. Nor shall any action operate to deny to the recipient the recovery for that portion of any damages not covered hereunder.

(c) The department shall likewise have the authority to recover the cost of benefits for medical care provided to indigent persons from third persons, whether or not the care was provided pursuant to the Arkansas Health Care Access Program, another program administered by the department, or a program administered through another department or agency of state government. The department shall remit to other departments or agencies of state government any amounts recovered, less its pro rata share and costs of collection, for care provided by them.

(d)(1) In actions in tort hereunder, no contributory or comparative fault of a recipient shall be attributed to the state, nor shall any restitution awarded to the state be

denied or reduced by any amount or percentage of fault attributed to a recipient.

(2) Notwithstanding subdivision (d)(1) of this section, if the recipient used a device, machine, or product after being warned, either verbally or in writing, that the use, misuse, or improper operation of the device, machine, or product was dangerous, risky, or could result in injury or harm to the recipient, then the statutory or common law defenses of contributory or comparative fault or negligence that could be asserted by the defendant against the recipient may also be asserted by the defendant in any action by the department or other agency of state government, and if the defenses are supported by the evidence, then recovery may be denied or reduced in the same manner as if the recipient were the plaintiff.

20-77-302. Action by recipient alone – Reimbursement of division.

(a) When an action or claim is brought by a medical assistance recipient or his or her legal representative against a third party who may be liable for injury, disease, disability, or death of a medical assistance recipient, any settlement, judgment, or award obtained is subject to the division's claim for reimbursement of the benefits provided to the recipient under the medical assistance program.

(b) In the event of judgment or award in a suit or claim against a third party, if the action or claim is prosecuted by the recipient alone, the court or agency shall first order paid from any judgment or award the reasonable litigation expenses and attorney's fees. After the payment of these expenses and attorney's fees, the court or agency

shall order that the Department of Human Services receive an amount sufficient to reimburse the department the full amount of benefits paid on behalf of the recipient under the medical assistance program. The remainder shall be awarded to the medical assistance recipient.

20-77-303. Action by division and recipient.

(a) If an action is prosecuted both by the recipient and the division against a third person who is liable for injury, disease, or disability of the recipient, then in the event of judgment or award in a suit or claim against the third party, the court shall first order paid from any judgment or award the reasonable litigation expenses incurred in prosecution of the action or claim, together with reasonable attorney's fees based solely on the services rendered for the benefit of the recipient.

(b) After payment of expenses and attorney's fees, the court shall order that the division receive an amount sufficient to reimburse the division the full amount of benefits paid on behalf of the recipient under the medical assistance program.

(c) The remainder shall be awarded to the medical assistance recipient.

20-77-304. Notice of action or claim – Intervention or consolidation.

(a)(1) If either the medical assistance recipient or the division brings an action or claim against a third person, the recipient or Department of Human Services

shall, within thirty (30) days of filing the action, give to the other party written notice of the action or claim by personal service or registered mail.

(2) This notice shall contain the names of the third person and the court in which the action is brought.

(3) Proof of the notice shall be filed in the action.

(4) If an action or claim is brought by either the department or recipient, the other may, at any time before trial on the facts, become a party to the action or shall consolidate his or her action or claim with the other if brought independently.

(b) If the recipient, his or her guardian, personal representative, estate, or survivors bring an action against the third person who may be liable for injury, disease, or disability, then notice of institution of the legal proceedings and notice of settlement shall be given the Director of the Department of Human Services. All notices shall be given by the attorney retained to assert the recipient's claim, or by the recipient, his or her guardian, personal representative, estate, or survivors if no attorney is retained.

20-77-305. Notice to Department of Human Services of award or settlement by recipient required.

(a) No judgment, award, or settlement in any action or claim by a medical assistance recipient to recover damages for injuries, disease, or disability, in which the Department of Human Services has an interest, shall be satisfied without first giving the department notice and a reasonable opportunity to establish its interest.

(b) If a recipient, his or her guardian, attorney, or personal representative disposes of the funds that are to be held for the benefit of the department under this section without the written approval of the department, that person shall be liable to the department for any amount that, as a result of the disposition of the funds, is not recoverable by the department.

20-77-306. Liability of third parties to Department of Human Services.

All parties who were legally liable for any or part of any medical cost of an injury, disease, disability, or condition requiring medical treatment for which the Medicaid program, established by § 20-77-102 has paid, or has assumed liability to pay, shall be liable to the Department of Human Services for the amount of their liability to the extent that the department has paid or agreed to pay.

20-77-307. Assignment to Department of Human Services of rights of recovery.

(a) As a condition of eligibility, every Medicaid applicant shall automatically assign his or her right to any settlement, judgment, or award which may be obtained against any third party to the Department of Human Services to the full extent of any amount which may be paid by Medicaid for the benefit of the applicant.

(b) The application for Medicaid benefits shall, in itself, constitute an assignment by operation of law.

(c) The assignment shall be considered a statutory lien on any settlement, judgment, or award received by the recipient from a third party.

(d) Every Medicaid applicant, as a condition of eligibility, shall cooperate in establishing paternity, except for good cause shown, for a child born out of wedlock for whom the recipient can legally assign rights, in obtaining medical care, support, and payments for himself or herself or any other person for whom the individual can legally assign rights, and in identifying and providing information to assist the department and the Office of Child Support Enforcement in pursuing any liable third party.

S. REP. 99-146
P.L. 99-272, COMPREHENSIVE OMNIBUS BUDGET . . .
SENATE REPORT NO. 99-146
October 2, 1985

5. Enhance Third-Party Liability Collections

Current law. – Medicaid is intended to be the payer of last resort, that is, other available resources must be used before Medicaid pays for the care of an individual enrolled in the Medicaid program.

Explanation of provision. – The provision would require the Secretary to issue regulations so that the States:

a. collect sufficient information to identify third party liabilities,

b. computer match information about the beneficiary with other data bases, as specified by the Secretary, and

c. use that information to pursue collections according to a plan approved by the Secretary of Health and Human Services.

The regulations would also provide that the States be financially penalized for not collecting the required information or not following through with the agreed-on collection plan. The provision would also make disclosure of third party liability a condition of eligibility for Medicaid. The provision clarifies the responsibility of Medicaid recipients for copayments and deductibles when third parties are liable for payments on their behalf. The provision would also clarify that Medicaid is the payer of last resort with respect to self-insured plans.

Effective date. – October 1, 1985.

DAB No. 1561 (1996)

Department of Health and Human Services (H.H.S.)
Departmental Appeals Board

Appellate Division

WASHINGTON STATE DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Docket No. A-95-159
Control No. A-10-93-00017
Decision No. 1561
February 7, 1996

DECISION

The Washington State Department of Social and Health Services (Washington or State) appealed a determination by the Health Care Financing Administration (HCFA) disallowing $75,395 in federal financial participation (FFP) claimed under title XIX (Medicaid) of the Social Security Act (Act). The disallowance represents the federal share of amounts which HCFA determined Washington should have collected from third party liability (TPL) settlements and awards received by Medicaid recipients from June 1, 1992 through August 31, 1993. HCFA determined that these amounts should have been credited against the State's previous claims for its expenditures on behalf of these recipients.

Under Washington law, when the State provides medical assistance to a Medicaid recipient because of an injury for which a third party is liable, Washington is subrogated to the recipient's rights against the recovery from any liable party and has a lien to the extent of the value of the medical assistance provided. This lien is subject to reduction for a proportionate share of attorney's

fees, and may be compromised by the State. This disallowance was based on an audit by the Office of Inspector General (OIG) of ten judgmentally-selected casualty cases closed by the State. The OIG found that $137,032 ($75,395 in FFP) in available settlement monies were distributed by Washington to recipients rather than being retained for full reimbursement to the Medicaid program for its costs of medical assistance under the State's application of its compromise provision (five cases) or its attorney's fees provision (five cases). HCFA determined that, under the Act, HCFA must be fully reimbursed for the federal share before the recipient may receive any money from a TPL settlement or award. HCFA therefore disallowed the federal share of TPL payments that Washington allowed the recipients to retain.

The Board has previously addressed a similar state TPL recovery system in California Dept. of Health Services, DAB No. 1504 (1995) (California). In that decision, the Board concluded that the Act requires states to fully reimburse HCFA for the federal share of medical assistance expenditures resulting from the acts of a liable third party before allowing a recipient to receive money from a TPL settlement or award. HCFA contended that the Board's rationale in that case was controlling here. Washington maintained that its compromise system was materially different from California's, and that its system was consistent with Medicaid TPL requirements. Washington also contended that its attorney's fees provision properly allocated to Medicaid its share of the cost of recovery.

Below we set forth the relevant federal authority and Washington's statutory authority, and we summarize the California decision. We then analyze the parties' arguments in this case and determine that Washington's

compromise provision is inconsistent with the Act's TPL recovery provisions, but its attorney's fees provision is consistent. Accordingly, we conclude that the disallowance of the amounts related to the compromise cases should be upheld and the disallowance of the amounts related to attorney's fees should be reversed.

RELEVANT FEDERAL AUTHORITY

The Act requires a state to take "all reasonable measures to ascertain the legal liability of third parties . . . to pay for care and services available under the [Medicaid state] plan. . . ." Section 1902(a)(25)(A). In cases where liability is found to exist after medical assistance is provided, "the State . . . will seek reimbursement for such assistance to the extent of such legal liability." Section 1902(a)(25)(B). A state is not required to seek such reimbursement if "the amount of reimbursement the State can reasonably expect to recover exceeds the costs of such recovery. . . ." *Id.*

Applicants for Medicaid are required to assign to the state their rights to "payment for medical care from any third party" and to cooperate with the state's pursuit of third party payment. Section 1912(a). The amount collected under such an assignment –

shall be retained by the State as is necessary to reimburse it for medical assistance payments made on behalf of an individual with respect to whom such assignment was executed (with appropriate reimbursement of the Federal Government to the extent of its participation in the financing of such medical assistance), and the remainder of such amount collected shall be paid to such individual. Section 1912(b).

Legitimate costs of obtaining the settlement or award, such as attorney's fees, may be deducted prior to reimbursement of the Medicaid program. HCFA's State Medicaid Manual (SMM) § 3907, HCFA Exhibit (ex.) A.

RELEVANT WASHINGTON STATUTORY AUTHORITY

Under Washington state law, if Washington provides Medicaid benefits to a recipient because of an injury or illness for which a third party tortfeasor may be liable, the State is subrogated to the recipient's rights against the tortfeasor or the tortfeasor's insurer, or both, and has a lien to the extent of the value of the Medicaid benefits provided. Wash. Rev. Code § 74.09.180.[1] This lien is "upon any claim, right of action, settlement proceeds, money or benefits arising from an insurance program to which the recipient might be entitled. . . ." Wash. Rev. Code § 43.20B.060(3).[2] The lien is subject to Wash. Rev. Code

[1] RCW 74.09.180 reads – Chapter does not apply where another party liable – Exception – Subrogation – Lien – Reimbursement. The provisions of this chapter shall not apply to recipients whose personal injuries are occasioned by negligence or wrong of another: PROVIDED, HOWEVER, That the secretary may furnish assistance, under the provisions of this chapter, for the results of injuries to or illness of a recipient, and the department shall thereby be subrogated to the recipient's rights against the recovery had from any tort feasor or the tort feasor's insurer, or both, and shall have a lien thereupon to the extent of the value of the assistance furnished by the department. To secure reimbursement for assistance provided under this section, the department may pursue its remedies under RCW 43.20B.060.

[2] RCW 43.20B.060 provides, in pertinent part –

> Reimbursement for medical care or residential care – Lien – Subrogation. (1) To secure reimbursement of any assistance paid under chapter 74.09 RCW or reimbursement for any residential care provided by the department at a hospital for the mentally ill or habilitative care center for

(Continued on following page)

§ 43.20B.050(1), referred to by the OIG as Washington's compromise provision, which provides that:

> No settlement made by and between the recipient and tort feasor and/or insurer shall discharge or otherwise compromise the lien created in RCW 43.20B.060 without the express written consent of the secretary [of Social and Health Services] . . . or the secretary's designee. Discretion to compromise such liens rests solely with the secretary or the secretary's designee.

The lien is also subject to Washington's attorney's fees provision:

> If recovery is made by the department under this section and the subrogation is fully or partially satisfied through an action brought by or on behalf of the recipient, the amount paid to the

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> the developmentally disabled, as a result of injuries to or illness of a recipient caused by the negligence or wrong of another, the department shall be subrogated to the recipient's rights against the tort feasor or the tort feasor's insurer, or both. (2) The department shall have a lien upon any recovery by or on behalf of the recipient from such tort feasor or the tort feasor's insurer, or both to the extent of the value of the assistance paid or residential care provided by the department, ...
>
> . . .
>
> (3) The lien of the department shall be upon any claim, right of action, settlement proceeds, money, or benefits arising from an insurance program to which the recipient might be entitled (a) against the tort feasor or insurer of the tort feasor, or both, and (b) under any contract of insurance purchased by the recipient or by any other person providing coverage for the illness or injuries for which the assistance or residential care is paid or provided by the department.

> department shall bear its proportionate share of attorneys' fees and costs.

Wash Rev. Code § 43.20B.060(4).[3]

The State provided an affidavit from the chief of the unit responsible for TPL recoveries explaining how these statutory provisions are implemented. *See* State ex. 12. She stated that, in casualty cases where a third party tortfeasor is alleged to be liable, the State initially asserts a lien in the full amount of medical expenses related to the injuries. The unit later makes a case-by-case analysis of each settlement. Washington may reduce the amount of the lien to less than Medicaid expenditures when the settlement amount is not sufficient to pay all medical expenses and other types of damages. *Id.* at 2. The unit

[3] RCW 43.20B.060(4) further provides –

> The determination of the proportionate share to be borne by the department shall be based upon: (a) The fees and costs approved by the court in which the action was initiated; or (b) The written agreement between the attorney and client which establishes fees and costs when fees and costs are not addressed by the court. (c) When fees and costs have been approved by a court, after notice to the department, the department shall have the right to be heard on the matter of attorneys' fees and costs or its proportionate share. (d) When fees and costs have not been addressed by the court, the department shall receive at the time of settlement a copy of the written agreement between the attorney and client which establishes fees and costs and may request and examine documentation of fees and costs associated with the case. The department may bring an action in superior court to void a settlement if it believes the attorneys' calculation of its proportionate share of fees and costs is inconsistent with the written agreement between the attorney and client which establishes fees and costs or if the fees and costs associated with the case are exorbitant in relation to cases of a similar nature.

determines the reduction of the lien for attorney's fees and costs by taking the total lien amount divided by the total settlement amount to obtain the percentage the State will allow of the attorney's fees and costs as a deduction from the lien amount. *Id.* at 2-3.

THE CALIFORNIA DECISION

In California, HCFA disallowed the federal share of TPL payments that California allowed recipients to retain even though Medicaid was not fully reimbursed. The Board upheld HCFA's position that the Act requires states to fully reimburse HCFA for the federal share of medical assistance expenditures resulting from the acts of a liable third party before allowing a recipient to receive money from a TPL settlement or award. Specifically, the Board found that three provisions of the Act supported this result:

> . Section 1912(a)(1)(A), which requires all recipients to execute an assignment of rights "to payment for medical care from any third party;"
>
> . Section 1902(a)(25)(B), which requires states to seek TPL reimbursement to the extent of a third party's liability; and
>
> . Section 1912(b), which provides that any amount a state collects under a recipient's assignment to payment for medical care must be used first to reimburse the Medicaid program for medical assistance payments and that the recipient is entitled only to the remainder.

The Board determined that HCFA's position was directly supported by these provisions of the Act. Recipients, as a condition of eligibility, must assign their rights

to payment for medical care. States are then charged with the responsibility of seeking third party recovery pursuant to such assignments. States are further required to seek as much reimbursement as possible, i.e., to the extent of the third party's liability. Finally, when a recovery is made, the Act sets forth a distribution scheme which requires the Medicaid program to be reimbursed prior to distributing any funds to the recipient. While section 1912(a) refers to assignment only of "payment for medical care," the statutory scheme as a whole contemplates that the actual recovery might be greater and, if it is, that Medicaid should be paid first.

The Board determined further that HCFA's position is also consistent with the purposes behind Medicaid TPL requirements: to make Medicaid the payor of last resort where there is a liable third party, so as to reduce Medicaid expenditures. In 1985, when Congress amended the Act to strengthen TPL recovery requirements, the accompanying legislative history provided: "Medicaid is intended to be the payor of last resort; that is, other available resources must be used before Medicaid pays for the care of an individual enrolled in the Medicaid program." Consolidated Omnibus Budget Reconciliation Act of 1985, H.R. Conf. Rep. No. 453, 99th Cong., 1st Sess. 542 (1985), reprinted in Legislative History of Titles I-XX of the Social Security Act, Vol. XXII, 99th Congress 1985-1986, Part 1. DAB No. 1504, at 7. The Board found that the language clearly indicates that Congress intended for the Medicaid program to be reimbursed from available third party sources to the fullest extent possible.

The Board noted that it had repeatedly held that it will not substitute its judgment for, or overturn, a reasonable interpretation of the agency charged with administering

a statute merely because there may be an alternative interpretation which arguably is also permissible. DAB No. 1504, at 8, citing Georgia Dept. of Human Resources, DAB No. 995 (1988); Missouri Dept. of Social Services, DAB No. 468 (1983).

ANALYSIS

Washington argued that HCFA had misapplied the Act, that Washington's TPL process was distinguishable from California's, and that HCFA had approved Washington's TPL process or alternatively, had failed to give it adequate notice that the process violated the Act. In the first section of analysis we discuss Washington's arguments and explain why we conclude that HCFA is entitled to impose a disallowance as to the compromise cases. In the second section of the analysis we discuss Washington's attorney's fees provision and why the disallowance of costs for payment of attorney's fees should be reversed.

A. The Compromise Provision

1. Whether a state must assert a priority over the recipient's casualty award to the full extent of the state's expenses

Washington argued there was no legal basis in the Act for HCFA's insistence that a recipient "transfer ownership to the state of an entire tort settlement that is insufficient to compensate the recipient for medical and other injuries for which the tortfeasor is liable" or for HCFA's insistence that recipient's assignment of medical damages gives a state a priority over the award to the extent of its costs. Washington Opening Brief (Br.) at 6-7. Washington relied on section 1912(a), which requires a Medicaid recipient to

assign his or her rights to payment for medical support and other medical care; on section 1902(a)(25)(A), which requires a state to take reasonable measures to ascertain the legal liability of third parties to pay for Medicaid care and services; and on section 1912(b), which sets forth the priority for distribution of the amount "collected by the State under an assignment."

The Board dealt with these arguments in California. Below, we restate our reasoning in that case.

First, HCFA has not taken the position that a recipient assigns or loses his/her right to seek compensation for injuries beyond the cost of medical care, nor does HCFA assume that the recipient's recovery represents only payment for medical care. Rather, HCFA's position is that, where there is a third party that is responsible for paying a recipient's medical expenses, the recipient may not recover money for him/herself until the federal government is reimbursed for its expenditures for the recipient's medical care.

Second, for the following reasons, HCFA may require a state to assert a collection priority over funds obtained by Medicaid recipients in TPL suits even though the distribution methodology set forth in section 1912(b) refers only to payments collected pursuant to assignments for medical care.

> . In cases where a third party has caused the need for medical care and is liable for its payment, the Act looks to that third party to reimburse the public. Section 1902(a)(25)(B) requires that "the State . . . will seek reimbursement for such assistance to the extent of such legal liability." HCFA reasonably construed this provision to require states to pursue the full claim against a third party.
>
> . HCFA reasonably read the Act to condition the availability of Medicaid funds on the recipient's agreement to reimburse Medicaid to the extent of a third party's liability. Therefore, Medicaid has superior status to the recipient in relation to the tortfeasor to recover costs Medicaid incurred on behalf of the recipient on the condition that it would be reimbursed if there was a liable third party from whom a recovery was collected.
>
> . HCFA has reasonably insisted on its right to characterize recoveries from third parties first as payments for medical care. This characterization prevents manipulation of tort awards by recipients who seek to prevent the public from being reimbursed for the funds it has advanced for their medical care (e.g., by suing for pain and suffering or lost wages rather than for medical costs). Without it, TPL recoveries would be subject to a wide range of interpretations about what was appropriately considered payment for medical care.

Therefore, we reject Washington's position that HCFA has misinterpreted the meaning of sections 1902(a)(25)(A) and 1912(a) and (b) of the Act.

2. Whether Washington's TPL system is distinguishable from California's TPL system

Washington argued that its TPL program was distinguishable from California's because, rather than reserving a statutorily set percentage recovery for Medicaid recipients, Washington reviews the circumstances in each individual settlement. According to Washington, it only

approves a compromise which would allow the Medicaid recipient to retain a portion of a settlement when it determines that recovery to the State would be less if it forced the recipient to litigate the question of liability. Washington stated that its goal "in every case is to maximize reimbursement to the Medicaid program" and that "[a] reduction in the State's recovery from a settlement or judgment is only considered when the settlement amount is not sufficient to pay all [medical and non-medical] expenses." Washington Br. at 5.

We do not find Washington's system different from California's in any material way. While Washington asserted that its case-by-case determinations maximize its TPL recoveries, California made similar claims about its system. DAB No. 1504, at 13. Therefore, even though California's system relied on a formula for determining the amount of its recovery, the reason California professed to use the formula (maximizing TPL recoveries) and the result of California's system were the same as in Washington. Under both systems, Medicaid recipients were allowed to retain portions of casualty awards even though the Medicaid program had not been reimbursed to the full extent of its participation in the recipient's costs.

3. Whether HCFA approved Washington's TPL system or failed to give it adequate notice that its TPL system was contrary to the Act

Washington also asserted that HCFA approved Washington's Medicaid state plan with "full knowledge and understanding of the manner and methods employed in casualty recoveries, including compromises, settlement, and attorney fee sharing." Washington Br. at 2. Washington concluded that HCFA should be estopped from imposing this

disallowance given its alleged approval of Washington's practices. *Id.* at 6. We note initially that it is not clear that estoppel will ever lie against the federal government, *Office of Personnel Management v. Richmond*, 496 U.S. 414, 423-34 (1990), and if available at all, is probably not available absent affirmative misconduct by the federal government. *Schweiker v. Hansen*, 450 U.S. 785 (1981); *see also Wisconsin Dept. of Health and Social Services*, DAB No. 1493 (1994). But even if estoppel could lie against HCFA, Washington did not prove the elements of estoppel in this case. A party seeking to assert estoppel must prove that: 1) the party against whom estoppel is sought made false representations; 2) the party claiming estoppel relied on the false representations to the party's detriment; and 3) the reliance was reasonable, in that the party claiming the estoppel neither knew nor should have known that its adversary's conduct was misleading. *Heckler v. Community Health Services*, 467 U.S. 51, 59 (1984). Further, erroneous oral advice is inadequate, as a matter of law, to estop the government from enforcing federal law. *Heckler v. Community Health Services*, 467 U.S. at 65; *see also Wisconsin* at 15. The Supreme Court reasoned in the Community Health Services case:

> The necessity for ensuring that governmental agents stay within the lawful scope of their authority, and that those who seek public funds act with scrupulous exactitude, argues strongly for the conclusion that an estoppel cannot be erected on the basis of the oral advice that underlay respondent's cost reports. That is especially true when a complex program such as Medicare is involved, in which the need for written records is manifest.

467 U.S. at 65.

For the following reasons, Washington has failed to establish that any HCFA official represented to the State in writing that its TPL compromise practice was consistent with the Act.

. Washington argued that by approving its Medicaid state plan, HCFA approved its TPL practices. Washington Br. at 2. However, the provisions of Washington's Medicaid state plan submitted by the State as Exhibit 1 comport with the Act's statutory scheme on their face and do not even allude to Washington's compromise policy. *See* State ex. 1. Thus, we disagree that HCFA's approval of the state plan provisions somehow equates to HCFA's ratification of the State's practice of compromising TPL recovery on a case-by-case basis.

. Washington also provided an affidavit of a senior program manager of its state TPL system. State ex. 11. That manager claims that HCFA's approval of the Washington State Medicaid plan "was done with full knowledge and understanding of the manner and methods employed in casualty recoveries, including compromises, settlements and attorney fee sharing by the State of Washington. In addition, prior interpretations of policy and law, also provided through HCFA, affirmed the aforementioned as consistent with acceptable practices." State ex. 11 at 2. This affidavit is unpersuasive because it does not identify the manner in which HCFA obtained knowledge of Washington's system, nor specifically assert that HCFA was informed, prior to the OIG audit, that the State was actually allowing Medicaid recipients to retain part of the recovery before Medicaid was reimbursed in situations where this reduced reimbursement of the federal

share of medical assistance. The affidavit also does not identify to which "prior interpretations of policy and law, also provided by HCFA, . . ." the affiant is referring.

. Moreover, HCFA presented an affidavit of a HCFA reviewer that stated that his office informed Washington in 1989 that it should ensure that all possible TPL monies were recovered "in accordance with Federal Regulations which makes [sic] provisions for only the payment of reasonable attorney fees and court costs." HCFA ex. B at 13. Included as an attachment to the affidavits is a 1989 letter from the Associate Regional Administrator, HCFA, directing Washington to submit a corrective action plan.

Washington also contended that it did not have adequate notice that HCFA considered its TPL system to be contrary to the Act. We do not find this contention persuasive. As noted above, HCFA asserted that it informed Washington in 1989 in the course of a program review that it should modify its TPL procedures. Further, in 1990, HCFA amended the State Medicaid Manual (SMM) to provide that "[i]n liability situations, the Medicaid program must be fully reimbursed before the recipient can receive any money from the settlement or award." SMM § 3907.[4] This revision put Washington on notice that a compromise of individual settlements permitting a recipient to keep settlement money before the Medicaid program was fully reimbursed was contrary to HCFA's interpretation of the requirements of the Act.

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[4] Amendments to the SMM are routinely provided to states, and Washington did not deny receiving the amendment in a timely manner.

Thus, Washington's contentions that it did not have notice of HCFA's interpretation of the TPL provisions of the Act and that HCFA should be estopped from taking this disallowance fail. Moreover, in light of our conclusion that Washington was on notice of HCFA's interpretation of the Act's TPL provisions, Washington's argument that HCFA should now be prevented from applying its interpretation of the Act "retroactively" also fails.

4. Whether Washington exercised its compromise authority consistent with federal regulations

Washington argued that it exercised its compromise authority pursuant to 42 C.F.R. § 433.139(f), which grants states a measure of discretion in deciding when to pursue third party reimbursement. Washington explained that in each of the disallowed compromise cases the amount of the settlement was not sufficient to compensate the recipient both for the damages suffered for medical injuries, which were assigned to the State, and for other damages to the recipient like wage loss and pain and suffering.[5] Washington Br. at 8. It represented that if it had not compromised its claim, the cases would not have settled and the State would have assumed the risk of an even greater reduction to its claim resulting from an adverse judgment or an unfavorable judicial apportionment of damages. Washington Br. at 9. Therefore, Washington argued, its decision to compromise these claims was within the discretion

[5] For example, in case number 1, the Medicaid payment was $204,055, while the total settlement available was $35,000. In case number 2, the Medicaid payment was $28,320 and the total settlement was $25,000.

granted to it by 42 C.F.R. § 433.139(f). That section provides:

> (1) An agency must seek reimbursement from a liable third party on all claims for which it determines that the amount it reasonably expects to recover will be greater than the cost of recovery. Recovery efforts may be suspended or terminated only if they are not cost effective.
>
> (2) The State plan must specify the threshold amount or other guideline that the agency uses in determining whether to seek recovery of reimbursement from a liable third party, or describe the process by which the agency determines that seeking recovery of reimbursement would not be cost effective.
>
> (3) The State plan must also specify the dollar amount or period of time for which it will accumulate billings with respect to a particular liable third party in making the decision whether to seek recovery of reimbursement.

The State plan provisions submitted by Washington in this case provide for a threshold amount of $20.00. State ex. 1 at sixth unnumbered page ("Attachment 4.22-B"). Washington's statutory compromise provisions are not referenced. The State's TPL recovery unit chief stated that, in the cases involved here –

> it was determined, after investigation of the relevant facts and circumstances and discussions with the attorneys involved, that the cost to the Department would be less to compromise the claim, allowing the client to retain some funds, than to force a lawsuit against the responsible party. The costs plus the probability of a defense

verdict made it a prudent decision to compromise the Department's lien.

State ex. 12, at 2.

Section 433.139(f) does not give Washington the discretion to allow a recipient to retain funds that are due Medicaid. Rather, it requires the State to set forth in its State plan how it determines that the amount it reasonably expects to recover will be greater than the cost of recovery. Here, the State did not set forth the guidelines it uses in determining that pursuit of reimbursement in a particular case is not cost-effective, either in its state plan or in the affidavit of its TPL recovery unit chief. Instead, Washington relied upon its own subjective policy determination that permitting compromise of its liens will maximize TPL recoveries.

We note that California also argued that its system was in full compliance with federal law and regulations on the grounds that it "balance[d] expectant costs with the potential recovery." California at 13. Specifically, California argued that, by allowing victims to share in awards, it created an incentive to seek out and pursue liable third parties, thereby maximizing pursuit and shifting initial costs from California to the victim, and that its program was cost effective.

As in California, we do not find arguments concerning the cost-benefit aspects of Washington's TPL system persuasive for the following reasons:

. The alleged effectiveness of Washington's statutory scheme is not the criterion by which we must evaluate this disallowance. Rather, we must apply the Act, as reasonably interpreted by HCFA. We have explained why, under that criterion, Washington's system does not comply with federal law.

. The role of evaluating the practical considerations that Washington advanced in support of its system belongs to HCFA, not the Board. As the administering agency, HCFA has the expertise and knowledge to weigh the benefits of Washington's system against the adverse effects of such a system on the operation of the Medicaid program. Moreover, half of the Medicaid funds the State is allowing the victim to keep came from the federal treasury. Consequently, HCFA is the entity which is logically charged with the responsibility of deciding what constitutes a fair balance for this aspect of the Medicaid program. To allow the many jurisdictions which participate in the Medicaid program the discretion to set that balance for third party casualty claims could undermine the TPL system and lead to divergent treatment of similarly situated recipients. Further, as HCFA has said previously, a state is free to allow recipients to retain the state's share of the recovery if the state believes that is an equitable result. California at 14.

. While Washington maintained that its compromise practice was necessary to make its TPL recovery system work, HCFA could reasonably conclude otherwise. For example, even if Washington asserted a complete priority over the recoveries, private attorneys would continue to have a financial incentive to take these cases because they would continue to be compensated first. Further, recipients are obligated under section 1912(a)(1)(C) of the Act to cooperate with Washington's pursuit of third party payment as a condition of eligibility, regardless of whether they retain any third party payment.

. It is not unfair to completely or substantially deny Medicaid recipients access to their settlements. If Medicaid had not paid their medical expenses, these recipients would have both unrestricted access to their settlements and enormous medical debts to be paid from those settlements. As Medicaid recipients, they do not have such debts because the public has paid their medical expenses. Therefore, in cases where Medicaid has incurred the "debt" for recipients, it is not unfair for HCFA to require complete reimbursement from these liability funds.

In summary, HCFA has the authority and the expertise to interpret the Act and to evaluate the practical considerations involved with seeking third party reimbursement from personal injury settlements and awards. In this case, HCFA has reasonably interpreted the Act to preclude systems which allow recipients to retain TPL payments from which the federal share of Medicaid expenditures has not been deducted. For the preceding reasons, we uphold the disallowance of the amounts associated with the five cases in which Washington applied its compromise provision to permit recipients to receive moneys due Medicaid.

B. The Attorney's Fees Provision

Washington contended that its method of calculating attorney's fees properly allocated to Medicaid its appropriate share of the cost of recovery. Washington maintained that the OIG's method imposed all of these costs on the recipient.

Washington offered the following example of how the two systems operated:

Assume a $10,000 settlement where attorney's fees (and costs) were $3,000 and Medicaid's outlay for medical expenses was $5,000.

OIG's Method

$10,000	settlement amt.
- 3,000	attorney's fees
7,000	
- 5,000	Medicaid outlay
$ 2,000	recipient's recovery

Washington's Method

$ 5,000 / $10,000	Medicaid outlay / settlement amount	= 50% Medicaid's share of recovery costs
50% ($3,000)	Medicaid's atty's fees % of recovery costs	= $1,500 Medicaid's share of recovery costs

$10,000	settlement amt.
- 1,500	Medicaid's share of recovery costs
- 5,000	Medicaid's outlay
$ 3,500	recipients recovery

Under the OIG's method, both the attorney's fees and Medicaid's share are deducted before the recipient shares in the recovery. According to Washington, this example shows that the OIG's method results in Medicaid bearing none of the costs of recovery. Under Washington's method, Medicaid is assessed a share of the attorney's fees proportionate with its share of the settlement proceeds – one-half, in the example displayed above – and the recipient also pays his or her proportionate share of the costs of recovery. Washington contended that its method fairly

allocates the costs between the recipient and Medicaid, and comports with SMM § 3907, cited by HCFA, which states, "Legitimate costs of obtaining the settlement or award, such as attorney fees, may be deducted prior to reimbursement to the Medicaid program."

We conclude that Washington's proportional assessment of attorney's fees against the Medicaid program is appropriate. Washington's assessment of attorney's fees is consistent with SMM § 3907, which authorizes deduction of attorney's fees prior to reimbursement of the Medicaid program.[6] The OIG method used in this case results in Medicaid bearing none of the legitimate costs of obtaining the settlement and is patently unfair. Moreover, we note that in the California case, California used, without objection from the OIG, a method of deducting attorney's fees from the settlements similar to Washington's.

HCFA's only response to Washington's contention was that the allegedly unfair result was due to the State relying on private attorneys rather than going after the TPL amount itself, and that Washington cannot abrogate its responsibility in this manner. HCFA's response to Washington's arguments was not persuasive for at least two reasons. First, nothing in the Act or regulations indicates that reliance on private attorneys for pursuit of third party recoveries is impermissible. Second, if the State pursued TPL recovery itself, the same problem would result: the Medicaid program would incur costs for the work of attorneys.

[6] We note that Washington has included provisions in its statute which prevent attorney's fees from being manipulated to impose on the State more than its fair share of a reasonable fee. *See* text of footnote 3.

Based on the reasons above, we reverse the portion of the disallowance relating to apportionment of attorney's fees.

CONCLUSION

Based on the above analysis, we uphold HCFA's disallowance of $69,687 FFP for Washington's compromise cases and reverse HCFA's disallowance of $5,708 for Washington's attorney's fees cases.[7]

Judith A. Ballard

Cecilia Sparks Ford

M. Terry Johnson

Presiding Board Member

[7] In its disallowance letter, HCFA instructed Washington to "recalculate the distribution of settlements and awards made after August 31, 1993, where your department has applied the state's compromise and attorney fees provisions to casualty cases" and to "make a decreasing adjustment in the amount determined that should have been retained by your department to fully reimburse Medicaid." Disallowance Letter of June 9, 1995, at 4. In its Notice of Appeal, Washington referred to this "recalculated amount" as being in dispute in this case. Notice of Appeal at 1. In its Reply Brief, Washington argued that, since HCFA's brief had addressed only the $75,395 disallowance, the Board should find that HCFA has acquiesced to the State's position on the issue of recalculation of settlements after August 31, 1993. Reply Brief at 2. To the contrary, it is clear from HCFA's brief that it did not acquiesce to Washington's position that its settlement policy was permissible so that no decreasing adjustment is needed. Consequently, HCFA's direction stands; the effect of this decision, however, is that the State need not recalculate recoveries of attorney's fees. Washington may appeal any future disallowances resulting from its recalculation.

DAB No. 1504 (1995)

Department of Health and Human Services (H.H.S.)
Departmental Appeals Board

Appellate Division

CALIFORNIA DEPARTMENT OF HEALTH SERVICES
Docket No. A-94-114
Control No. A-09-92-00095
Decision No. 1504
January 5, 1995

DECISION

The California Department of Health Services (California or State) appealed a determination by the Health Care Financing Administration (HCFA) disallowing $7,592,786 in federal financial participation (FFP) claimed under title XIX (Medicaid) of the Social Security Act (Act). The disallowance represents the federal share of amounts which HCFA determined California should have collected from third party liability (TPL) settlements and awards received by Medicaid recipients from July 1, 1988 through June 30, 1992. HCFA determined that these amounts should have been credited against California's previous claims for its expenditures on behalf of these recipients.

Under California law, when California provides medical benefits to a Medi-Cal (California's name for Medicaid) recipient because of an injury for which a third party is liable, California is entitled to recover the reasonable value of the benefits from that third party. This case arose because California did not fully recover, from TPL settlements and awards obtained by Medi-Cal recipients, reimbursement for the reasonable value of the Medi-Cal benefits it provided; instead, California allowed recipients

to retain at least 50% of the settlement or award. HCFA determined that, under the Act, HCFA must be fully reimbursed for the federal share before the recipient may receive any money from a TPL settlement or award. HCFA therefore disallowed the federal share of TPL payments that California allowed the recipients to retain.

California appealed this disallowance on the ground that HCFA had no authority under the Act to prohibit states from allowing recipients to retain portions of TPL payments which did not represent payment for medical care. California further argued that its TPL recovery program was highly successful and furthered federal TPL requirements by maximizing TPL recoveries while reducing TPL associated administrative expenses.

Based on our review of the evidence and argument in the record, and the relevant provisions of the Act, we conclude that HCFA's interpretation of the Act is a reasonable construction of its express terms and is supported by the legislative history. Further, California has had notice of HCFA's interpretation of these TPL provisions since 1988. Accordingly, we uphold the disallowance.

Relevant Federal Authority

The Act requires a state to take "all reasonable measures to ascertain the legal liability of third parties . . . to pay for care and services available under the [Medicaid] plan. . . ." Section 1902(a)(25)(A). In cases where liability is found to exist after medical assistance is provided, "the State . . . will seek reimbursement for such assistance to the extent of such legal liability." Section 1902(a)(25)(B). A state is not required to seek such reimbursement if "the

amount of reimbursement the State can reasonably expect to recover exceeds the costs of such recovery. . . ." *Id.*

Applicants for Medicaid are required to assign to the state their rights to "payment for medical care from any third party" and to cooperate with the state's pursuit of third party payment. Section 1912(a). The amount collected under such an assignment –

> shall be retained by the State as is necessary to reimburse it for medical assistance payments made on behalf of an individual with respect to whom such assignment was executed (with appropriate reimbursement of the Federal Government to the extent of its participation in the financing of such medical assistance), and the remainder of such amount collected shall be paid to such individual.

Section 1912(b).

Legitimate costs of obtaining the settlement or award, such as attorney's fees, may be deducted prior to reimbursement of the Medicaid program. HCFA's State Medicaid Manual (SMM) § 3907, HCFA Exhibit (Ex.) A.

Relevant California Statutory Authority

Under California law, if California provides Medi-Cal benefits to a recipient because of an injury for which a third party is liable, California is entitled to recover, from that third party, the reasonable value of the benefits it provided. Cal. Welf. & Inst. Code § 14124.71(a).

California has enacted a statutory scheme to effectuate such TPL recoveries from tortfeasors and their insurers. Cal. Welf. & Inst. Code §§ 14124.70-14124.90. Under

California's scheme, any settlement, judgment, or award obtained by a recipient is subject to California's claim for reimbursement of the Medi-Cal benefits. Cal. Welf. & Inst. Code § 14123.74. If a representative of a Medi-Cal recipient or the recipient brings an action against a third party who may be liable for an injury which has resulted in Medi-Cal expenditures, he or she must provide notice of the action to California. Cal. Welf. & Inst. Code § 14124.79. This notice enables California to perfect a lien upon any judgment or settlement that the recipient obtains from the third party. Cal. Welf. & Inst. Code §§ 14124.76, 14124.77. Further, after payment of the litigation costs and attorney's fees, California's lien is given priority in the distribution of any judgment or award obtained by the victim. Cal. Welf. & Inst. Code § 14124.74.

Under California's statutory scheme, any recovery by the Medi-Cal recipient is distributed pursuant to one of three alternative methods:

> o The 25% method. California Welfare and Institutions Code section 14124.72(d) provides that, where the action is brought by the victim (without California) and the victim incurs a personal liability to pay attorney's fees and costs of litigation, California's claim for reimbursement is limited to the amount of California's Medi-Cal expenditures, less a portion of the costs of litigation and 25% for attorney's fees.[1]

[1] Section 14124.72(d) provides:

> Where the action or claim is brought by the beneficiary alone and the beneficiary incurs a personal liability to pay attorney's fees and costs of litigation, the director's claim for reimbursement of the benefits provided to the beneficiary

(Continued on following page)

o The 50% method. California Welfare and Institutions Code section 14124.78 limits California's claim to not more than one half of the recipient's recovery after deducting for attorney's fees, litigation costs and medical expenses paid for by the recipient relating to the injury.[2]

o The waiver method. California Welfare and Institutions Code section 14124.71(b) allows California to waive part or all its claim on the lien and take less than it would be entitled to under the 25% or 50% method if it determines that waiver is appropriate.[3]

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shall be limited to the amount of the medical expenditures for the benefit of the beneficiary less 25 percent which represents the director's reasonable share of attorney's fees paid by the beneficiary and that portion of the cost of litigation expenses determined by multiplying the ratio of the full amount of expenditures to the full amount of the judgment, award or settlement.

[2] Section 14124.78 provides:

> Except as otherwise provided in this article, notwithstanding any other provision of law, the entire amount of any settlement of the injured beneficiary's action or claim, with or without suit, is subject to . . . [California's] claim for reimbursement of the benefits provided and any lien filed pursuant thereto, but in no event shall [California's] claim exceed one-half of the beneficiary's recovery after deducting for attorney's fees, litigation costs, and medical expenses relating to the injury paid by the beneficiary.

[3] Section 14124.71(b) provides:

The director may: * * *

> (2) Waive any such claim, in whole or in part, for the convenience of the director, or if the director determines that collection would result in undue hardship upon the person who suffered the injury, or in a wrongful death action upon the heirs of the deceased.

When California is notified that a settlement or judgment has occurred, California compares the collection obtainable under the 25% and the 50% methods. California collects the lower of the twoo [sic] identified amounts unless a waiver is appropriate under Welfare and Institutions Code section 14124.71(b). If it determines that a waiver is appropriate, California further reduces the amount it could have collected under the 25% or the 50% method.

The Federal Audit

The Office of the Inspector General of Audit Services (OIGOAS) examined State records concerning TPL recoveries for the period July 1, 1988 through June 30, 1992. A universe of 2,445 cases was defined by identifying all cases with transaction codes indicating that California's TPL collection was calculated pursuant to the 50% method under Welfare and Institutions Code section 14124.78 (transaction code 449) or was reduced pursuant to the waiver method under section 14124.71(b)(2) (transaction code 440). The auditors then reviewed a random sample of 300 cases in the universe to evaluate the amount California actually collected from the TPL settlements and awards.

For each sample case, OIGOAS calculated a Medicaid "net lien" by applying California's 25% method: the total Medicaid expenditures less a percentage for attorney's fees and a pro rata share of costs. It concluded this was the amount California should have sought from the recipient's third party recovery. OIGOAS then determined whether the amount of the settlement was sufficient to compensate the attorney, pay the litigation costs, and reimburse

California for the net lien amount. If it was, OIGOAS questioned the federal share of the difference between the net lien amount and the amount California collected. If the settlement amount was not sufficient, OIGOAS questioned the federal share of the difference between the amount of the settlement less actual legal fees and costs and the amount California collected.[4]

OIGOAS found that California did not give HCFA full financial credit in 241 of the 300 cases sampled. The majority of the cases (about two-thirds) involved the 50% rule, whereby California limited its recovery to half of the amount remaining after deducting for attorney's fees, litigation costs, and out-of-pocket medical expenses. The waiver rule made up most of the balance of cases. (Miscellaneous errors, chiefly mathematical and clerical, account for the remaining, small fraction of cases.)

OIGOAS projected the results of its sample case findings to the universe of 2,445 cases. By projecting its findings, OIGOAS determined that, at a minimum, the

[4] For example, in the case of C. M. (State Exhibit 2, line 9), the recipient received $106,983 in Medi-Cal benefits, obtained a liability settlement of $150,000, and incurred $48,506 in attorney's fees and $2,641 in costs. OIGOAS calculated the "net lien" by applying California's 25% percent [sic] method: it reduced the Medi-Cal benefits by 25% to account for legal fees ($106,983 x 25% = $26,746) and $1,884 for its pro rata share of costs (($106,983 / $150,000) x $2,641 = $1,884). Thus, OIGOAS determined that the Medi-Cal net lien was $78,353 ($106,983 - $26,746 - $1,884). However, in this case, California applied its 50% method rather than its 25% method and recovered only $49,426 ($150,000 - $48,506 [legal fees] - $2,641 [costs] = $98,853 x 50% = $49,426). OIGOAS therefore determined that there was an overall deficiency of $28,927 ($78,353 [net lien] - 49,426 [California's actual recovery] = $28,927) and a shortfall in the federal reimbursement of $14,463 ($28,927 x 50% FFP = $14,463).

federal share of the amount available but not collected by California was $7,592,786. HCFA adopted OIGOAS' audit recommendations and disallowed that amount.

Analysis

California appealed this disallowance on the grounds that HCFA had unreasonably prohibited California from allowing recipients to retain portions of TPL payments which did not represent payment for medical care.

HCFA took the position that the Act requires states to fully reimburse HCFA for the federal share of medical assistance expenditures resulting from the acts of a liable third party before allowing a recipient to receive money from a TPL settlement or award. Thus, according to HCFA, a state must collect from a recipient's TPL recovery, to the maximum extent possible after deducting attorney's fees and litigation costs, the full amount of its Medicaid expenditures and remit the federal share of the expenditures to HCFA. HCFA based its position on three provisions of the Act:

- Section 1912(a)(1)(A), which requires all recipients to execute an assignment of rights "to payment for medical care from any third party;"
- Section 1902(a)(25)(B), which requires states to seek TPL reimbursement to the extent of a third party's liability;
- Section 1912(b), which provides that any amount a state collects under a recipient's assignment to payment for medical care must be used first to reimburse the Medicaid program for medical assistance payments and that the recipient is entitled only to the remainder.

HCFA's position is directly supported by these provisions of the Act. Recipients, as a condition of eligibility, must assign their rights to payment for medical care. States are then charged with the responsibility of seeking third party recovery pursuant to such assignments. States are further required to seek as much reimbursement as possible, i.e., to the extent of the third party's liability. Finally, when a recovery is made, the Act sets forth a distribution scheme which requires the Medicaid program to be reimbursed prior to distributing any funds to the recipient. While section 1912(a) refers to assignment only of "payment for medical care," the statutory scheme as a whole contemplates that the actual recovery might be greater and, if it is, that Medicaid should be paid first.

HCFA's position is also consistent with the purposes behind Medicaid TPL requirements: to make Medicaid the payor of last resort where there is a liable third party, so as to reduce Medicaid expenditures. In 1985, when Congress amended the Act to strengthen TPL recovery requirements, the accompanying legislative history provided: "Medicaid is intended to be the payor of last resort; that is, other available resources must be used before Medicaid pays for the care of an individual enrolled in the Medicaid program." Consolidated Omnibus Budget Reconciliation Act of 1985, H.R. Conf. Rep. No. 453, 99th Cong., 1st Sess. 542 (1985), reprinted in Legislative History of Titles I-XX of the Social Security Act, Vol. XXII, 99th Congress 1985-1986, Part 1. The language clearly indicates that Congress intended for the Medicaid program to be reimbursed from available third party sources to the fullest extent possible.

Moreover, California has had timely notice of HCFA's construction of the statutory provisions relating to TPL

payments since June 1988. In Medicaid Regional Memorandum No. 88-10, HCFA expressly addressed the issue of "State lien laws which permit a Medicaid recipient, who initiates pursuit of TPL recovery from a liable third party, to keep a fixed percentage of the recovered amounts before the State (and Federal Government) receives its share of the settlement." In the memorandum, HCFA instructed states that

> [i]n the absence of specific State provisions assuring full reimbursement of the Federal share, the State laws in question would be in conflict with section 1912(b). As a result, the State's actual recovery becomes impermissibly reduced such that the full Federal share (based on the total net recovery) would not be refunded. The recipient has a right only to the remainder after Medicaid payments are fully reimbursed.

HCFA Ex. C.[5]

Since California had notice of HCFA's interpretation of the Act, and that interpretation is reasonable, HCFA's interpretation is entitled to deference in this case. The Board has repeatedly stated that it will not substitute its judgment for, or overturn, a reasonable interpretation of the agency charged with administering a statute merely because there may be an alternative interpretation which arguably is also permissible. Georgia Dept. of Human

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[5] Further, in 1990, HCFA amended the State Medicaid Manual to provide that "[i]n liability situations, the Medicaid program must be fully reimbursed before the recipient can receive any money from the settlement or award." § 3907 SMM, HCFA Ex. A. Finally, in 1991, HCFA specifically informed California that its method for distributing TPL personal injury settlements and awards was out of compliance with the Act. HCFA Ex. B.

Resources, DAB No. 995 (1988); Missouri Dept. of Social Services, DAB No. 468 (1983).

California challenged HCFA's interpretation by arguing that: (1) HCFA misconstrued the law of assignment and its application in TPL cases; (2) HCFA has no right to assert a priority over funds obtained by victims; (3) HCFA misapplied section 1902(a)(25)(B) of the Act; and (4) California's TPL program complies with federal law. Below we explain why we reject California's arguments in this case.

First, California argued that HCFA misconstrued the law of assignment. It pointed out that a Medicaid recipient is required by federal law to assign only his or her rights to payment for medical care. This assignment, California argued, does not prevent a recipient from seeking recovery for other aspects of the injury such as pain and suffering and lost wages. California argued that HCFA had incorrectly assumed that all of the money a recipient recovered from a third party represented the cost of medical care.

However, HCFA did not argue that a recipient cannot seek redress for injuries beyond the cost of medical care nor did it assume that the recipient's recovery must represent only payment for medical care. Rather, HCFA's position is that, where there is a third party or casualty insurer that is responsible for paying a recipient's medical expenses, the recipient may not recover money for him/herself until the federal government is reimbursed for its expenditures for the recipient's medical care. Moreover, while arguing that HCFA incorrectly assumed that 100% of a recipient's recovery was for medical expenses, California offered no factual basis its assumption that only 50% of a recipient's recovery was medical expenses. Instead,

California simply stated that "apportionment done on a 50:50 basis is symbolically fair." California Appeal Brief at 21.

HCFA's position, that it is entitled to be reimbursed first from the recipient's tort recovery, relates to California's second argument. California asserted that HCFA has no right to a collection priority over funds obtained by Medicaid recipients in TPL suits for two reasons. First, California argued that the distribution methodology set forth in section 1912(b), on which HCFA relied, establishes a priority in favor of the federal government only when a state initiates and obtains recovery for medical care, not when a recipient brings a legal action. Second, California argued that the distribution methodology set forth in section 1912(b) concerns only payments collected pursuant to assignments for medical care and does not govern distribution of recoveries for payments which are not for medical care.

We do not find these arguments persuasive. The distribution methodology set forth in section 1912(b) must be read in conjunction with section 1902(a)(25)(B), which requires states, not recipients, to seek third party reimbursement.[6] Therefore, California has an obligation to seek

[6] Under section 1912(a)(1)(c), recipients are required to cooperate with a state's pursuit of TPL reimbursement but they are not required to pursue such reimbursement themselves. The legislative history of this provision states: "The conference agreement follows the Senate amendment with a modification clarifying that individuals are required to identify, to the extent they are able, potentially liable insurers and other third parties, and to provide information to assist the State in pursuing third parties. Beneficiaries are not required to pursue the collection [of third party reimbursement] themselves. Pursuit is the responsibility of the provider or the State as provided elsewhere in this section." H. R. Conf. Rep. No. 453, at 544-545.

third party reimbursement to [sic] "to the extent of such liability." While California has structured its tort recovery system to encourage lawsuits by recipients and private attorneys rather than the State, it would be inconsistent with the purposes of the provisions to permit this structure to obviate California's obligation under section 1902(a)(25)(B) to seek third party reimbursement or to change the distribution methodology established by section 1912(b). Further, unless these private attorneys are considered to be acting on behalf of the State so that the "collections" that they effectuate are subject to the distribution requirements of section 1912(b), then California cannot reasonably rely on their efforts as meeting the section 1902(a)(25)(B) requirement.

To allow the distribution of a settlement or an award to turn on whether a recipient or a state initiated the liability action would distort the Medicaid TPL system. Under California's construction, recipients could avoid the third party recovery mandates of the Act simply by instituting the action themselves. California identified no rational basis which would justify such divergent treatment of similarly situated recipients, or the resulting loss to the federal treasury.

California argued further that HCFA had misread section 1912(b) to create a priority for itself over all funds recovered by the recipient. California argued that such a priority ignored the fact that these payments included amounts for things other than medical care. We reject California's construction of section 1912(b) for the following reasons:

> o In cases where a third party has caused the need for medical caree [sic] and is liable for its payment, the Act looks to that third party to

reimburse the public. Section 1902(a)(25)(B) requires that "the State . . . will seek reimbursement for such assistance to the extent of such legal liability." HCFA reasonably construed this provision to require states to pursue the full claim against a third party.

o HCFA reasonably read the Act to condition the availability of Medicaid funds on the recipient's agreement to reimburse Medicaid to the extent of a third party's liability. Therefore, Medicaid has superior status to the recipient in relation to the tortfeasor to recover costs Medicaid incurred on behalf of a recipient on the condition that it would be reimbursed if there was a liable third party from whom a recovery was collected.

o HCFA reasonably insisted on its right to characterize recoveries from third parties first as payments for medical care. This characterization prevents manipulation of tort awards by recipients who seek to prevent the public from being reimbursed for the funds it has advanced for their medical care (e.g., by suing for pain and suffering or lost wages rather than for medical costs). Without it, TPL recoveries would be subject to a wide range of interpretations about what was appropriately considered payment for medical care.

o Even though California objected to HCFA's assertion of a priority over all the funds recovered by a recipient, its own statutory scheme asserts a priority or "first lien" over a recipient's recovery, no matter how the particular damage components of that recovery might be characterized. Cal. Welf. & Inst. Code §§ 14124.71(a); 14124.72(c) and (d); 14124.74(a) and (b). Thus,

> California recognized that such a priority is essential to effectively collect TPL reimbursement. While California's scheme goes on to limit what California may claim pursuant to its lien and gives the director authority to waive part or all of the lien, the fact is that California asserts a priority over the recipient's entire recovery.[7] Therefore, California cannot reasonably maintain that a priority over recipients' damage awards is contrary to the Act.

Third, California argued that section 1902(a)(25)(B) merely provided for a "cost based" determination as to when it was appropriate to seek third party reimbursement and did not constitute "an independent requirement that the state collect the full amount of the cost of providing medical care from the victims' settlement of their claims." California Appeal Brief, at 19. It concluded that section 1902(a)(25)(B) could not be read to "quash or supersede lawful claims of the victim." *Id.*

We disagree with California's construction of this section. Sections 1902(a)(25)(B) and 1912(b), read together,

[7] Further, we note that, until 1976, under California's prior statutory scheme for recovering Medi-Cal expenses from tortfeasors, California was given a 100% priority over the award and did not have to reduce its lien to reflect attorney's fees. The current system was enacted after several state court decisions interfered with California's ability to recover from these awards and settlements. *See Reid v. Department of Health Care Services*, 55 C.A.3d 418 (1976); *Van Nuis v. L.A. Soap Co.*, 36 C.A.3d 222 (1973). The 50% limitation was included in the final version of the current statutory scheme. It represented a codification of "long-standing settlement guidelines and was added to assure that our lien recovery could not totally deprive a beneficiary of his recovery." Enrolled Bill Report, Bill No. AB3569, dated August 19, 1976 and submitted as an attachment to California letter of November 21, 1994.

require states to seek TPL reimbursement and to distribute any collection first to the Medicaid program and then to the victim. The fact that the victim may have other "lawful claims" for such things as pain and suffering or lost wages does not override Congress' intent, as evidenced by the terms of the Act, that the Medicaid program be fully reimbursed for its expenses before the victim shares in a TPL recovery. The cost-benefit language on which California relied merely creates a common-sense exception to the general federal mandate that states seek TPL recovery. Here, we are not dealing with a few isolated incidents where a state determined that pursuit of a liable third party would not be cost-effective but the recipient nevertheless pursued recovery. Instead, California's scheme is based on recovery by recipients. Failure to apply the distribution priority established in section 1902(a)(25)(B) in these circumstances would allow a state to defeat Congressional intent.

Fourth, California argued that its "successful third party liability program is in full compliance with the federal law and regulations." California Appeal Brief, at 20. This argument focused on the effectiveness of California's TPL recovery scheme which "balances expectant costs with the potential recovery." *Id.* Specifically, California argued that, by allowing victims to share in awards, it created an incentive to seek out and pursue liable third parties, thereby maximizing pursuit and shifting initial costs from California to the victim. It argued that the 50% apportionment was fair, created "a reasonable balance between the lawful claims of the victim and California," and ended "the potential legal battle over the limited funds" in which litigants would manipulate awards and settlements to exclude medical damages. *Id.* at 20, 21. It

pointed out that its waiver authority furthered the purposes of the Act by allowing California to condition the use of funds to avoid further public expenses. Finally, it represented that all these factors resulted in a cost effective program.

We do not find these arguments persuasive for the following reasons:

o The alleged effectiveness of California's statutory scheme is not the criteria by which we must evaluate this disallowance. Rather, we must apply the Act, as reasonably interpreted by HCFA. We have explained why, under that criterion, California's system does not comply with federal law.

o The role of evaluating the practical considerations that California advanced in support of its system belongs to HCFA, not the Board. As the administering agency, HCFA has the expertise and knowledge to weigh the benefits of California's system against the adverse effects of such a system on the operation of the Medicaid program.

o As for California's assertion that its scheme created a reasonable balance between the victim and the State, that argument ignores the fact that half of the Medi-Cal funds the State is allowing the victim to keep came from the federal treasury. Consequently, HCFA is the entity which is logically charged with the responsibility of deciding what constitutes a "reasonable balance" for this aspect of the Medicaid program. To allow the many jurisdictions which participate in the Medicaid program the discretion to set that balance for third party casualty claims could undermine the TPL system and lead to divergent

treatment of similarly situated recipients. Further, as HCFA as [sic] informed California, a state is free to allow recipients to retain the state's share of the FFP if they believe that is an equitable result.

o While California maintained that the 50% apportionment is necessary to make the TPL recovery system work, HCFA could reasonably conclude otherwise. For example, even if California had complete priority over the recoveries, private attorneys would continue to have a financial incentive to take these cases because they would continue to be compensated first. Further, recipients are obligated under section 1912(a)(1)(C) to cooperate with California's pursuit of third party payment as a condition of eligibility, regardless of whether they retain any third party payment.

o Contrary to what California argued, it is not unfair completely or substantially to deny Medicaid recipients access to their settlements. If Medicaid had not paid their medical expenses, these recipients would have both unrestricted access to their settlements and enormous medical debts to be paid from those settlements. As Medicaid recipients, they do not have such debts because the public has paid their medical expenses. Therefore, in cases where Medicaid has incurred the "debt" for recipients, it is not unfair for HCFA to require complete reimbursement from these liability funds.

o California is correct that its TPL recovery scheme, by imposing a lien on all of a recipient's recovery no matter how it is characterized, prevents recipients from structuring recoveries to exclude medical damages. However, California has the ability to prevent such problems by

amending its statutory scheme to eliminate both the 50% limit on amount it will claim and its discretion to reduce its lien.

o While California represented that its waiver method allows it to condition the use of funds to avoid further public expenses, it is free to use its share of the TPL recoveries to impose such conditions.

In summary, HCFA has the authority and the expertise to interpret the Act and to evaluate the practical considerations involved with seeking third party reimbursement from personal injury settlements and awards. In this case, HCFA has reasonably interpreted the Act to preclude systems which allow recipients to retain TPL payments from which the federal share of Medicaid expenditures has not been deducted.

Conclusion

For the preceding reasons, we uphold this disallowance.

Judith A. Ballard

Cecilia Sparks Ford

M. Terry Johnson

Presiding Board Member

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

433(D)-1-GEN;SEW

Region VIII
Federal Office Building
1961 Stout Street
Denver CO 80294

Sep 2, 1994

HEALTH CARE FINANCING ADMINISTRATION
REGIONAL IDENTICAL LETTER NO. 94-134

TO: STATE MEDICAID DIRECTORS

SUBJECT: THIRD PARTY LIABILITY RELATIONSHIP TO ISSUE OF LIENS

Federal law at section 1917(a) of the Social Security Act (the Act), and implementing regulations at 42 CFR 433.36 prohibit you from imposing liens against the property of any individual prior to his/her death because of medical assistance paid or to be paid on his/her behalf under the State plan, except in very limited circumstances.

However, section 1902(a)(25)(A) of the Act requires you to ascertain the legal liability of third parties to make payments which Medicaid would otherwise have to make. A third party is defined in the regulations at 42 CFR 433.136 as any individual, entity, or program that is, or may be, liable to pay all or part of the expenditures for medical assistance furnished under the State plan. This includes any monetary judgment or settlement from a tort or casualty liability claim. Where such a legal liability exists, section 1902(a)(25)(B) of the Act requires you to seek reimbursement for medical assistance payments already made.

A Medicaid recipient, at the time of application and as a condition of eligibility for Medicaid, assigns to the State his/her rights to payment from any third party and must cooperate with you in your pursuit of any third party who might be liable for payment, as required by section 1912(a)(1) of the Act. Thus, under this provision in Federal law and the implementing regulations at 42 CFR 433.145, you have claim to the amount recovered by the recipient, even though you may not have been a party to the litigation.

If, under State law, a lien is not being placed upon the Medicaid recipient's property, but rather is being placed upon the tortfeasor's (the defendant in the personal injury litigation) property or upon funds which are set aside to be used in a settlement of the litigation, but which have not become the recipient's property, then there would be no conflict with section 1917(a) of the Act. This is because section 1917(a) only precludes you from placing a lien on an individual's property.

However, under the circumstances described in this letter, you have an interest in the potential personal injury settlement when a recipient's rights to recover payment for medical care must have been assigned to you under section 1912 of the Act in order for him/her to be eligible for Medicaid. In that event, if you place a lien on these funds, it does not violate the Medicaid statute. However, you may not impose a lien on any of the recipient's property which has not been assigned to you.

If you have any questions, please call Sandra White at 303-844-6216, extension 376.

/s/ Gary Wilks
Gary Wilks
Associate Regional
Administrator
Division of Medicaid

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Region VI
1200 Main Tower Building
Dallas, Texas 75202

June 01, 1998

DALLAS REGIONAL MEDICAL SERVICES LETTER NO. 88-23

To: State Agencies Administering Approved Medical Assistance Plans

SUBJECT: State Third Party Liability (TPL) Subrogation Legislation

This is to advise you of a development in TPL subrogation legislation which is occurring in many States and which is in conflict with the Social Security Act. We refer to the passage of State lien laws which permit a Medicaid recipient, who initiates pursuit of TPL recovery from a liable third party, to keep a fixed percentage of the recovered amounts before the State (and Federal Government) receives its share of the settlement. Recently we were informed by counsel that these provisions are in conflict with Section 1912 of the Act.

Section 1902(a)(45) of the Act mandates, as a condition of eligibility, that recipients assign to the State, in accordance with Section 1912, their right to recover from third parties. Section 1912(b) of the Act states that the remainder of any amounts collected under an assignment pursuant to Section 1912(a) shall be paid to the recipient after the State recovers (with appropriate reimbursement to the Federal Government) what it paid on behalf of the recipient.

In the absence of specific State provisions assuring full reimbursement of the Federal share, the State laws in question would be in conflict with Section 1912(b). As a result, the State's actual recovery becomes impermissibly reduced such that the full Federal share (based on the total net recovery) would not be refunded. The recipient has a right only to the remainder after Medicaid payments are fully reimbursed.

While a State is certainly permitted to give part (or even all) of its recovery to a recipient, Section 1912 does not allow a State to give away the Federal share. Moreover, since Title XIX does not authorize any payments to the recipient until Medicaid is fully repaid, any payment to recipients can be made only after the State has credited its recovery and established the amount of the Federal share to be returned.

Furthermore, the only amounts which can be paid out prior to State recoupment are legitimate administrative expenses. This is based upon an interpretation of "net recovery" in Section 1903(d)(3) of the Act, which speaks about the pro rata share of the recovery to which the United States is equitably entitled. "Net recovery" is interpreted to mean the settlement amount less procurement costs, including attorney fees. The regulation which discusses the basic rule is applicable to Medicare beneficiaries (42 CFR 405.423(b) and (c)), but, by analogy, a similar application to Medicaid recipients can be made.

Supreme Court, U.S.
FILED
AUG 17 2005
OFFICE OF THE CLERK

(2)

No. 04-1506

In The Supreme Court of the United States

ARKANSAS DEPARTMENT
OF HUMAN SERVICES, et al.,

Petitioners,

vs.

HEIDI AHLBORN,

Respondent.

**On Petition For Writ Of Certiorari
To The United States Court Of Appeals
For The Eighth Circuit**

RESPONDENT'S BRIEF IN RESPONSE TO PETITION FOR WRIT OF CERTIORARI

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QUESTION PRESENTED

Whether 42 U.S.C. § 1396p(a)(1) permits a state Medicaid program to appropriate a recipient's monetary recovery upon a claim arising out of personal injury beyond the extent to which it represents compensation for past medical expenses.

TABLE OF CONTENTS

	Page
QUESTION PRESENTED	i
TABLE OF AUTHORITIES	iv
STATEMENT OF THE CASE	1
SUMMARY OF ARGUMENT	3
ARGUMENT	5
A. Certiorari Is Not Appropriate Because Of Any Conflict Between *Ahlborn* And Other Decisions	10
1. The Utah And Washington Decisions Which Conflict With *Ahlborn* Are Fundamentally Unsound; The New York Case Does Not Address The Anti-Lien Statute	10
2. *Ahlborn* Is Not In Conflict With The Second Circuit Decision Or That Of The North Dakota Court	12
3. *Ahlborn* Is In Harmony With The Decisional Law Of The Minnesota Supreme Court	14
4. Summary	14
B. Certiorari Is Not Appropriate Because Of Asserted Conflict Between *Ahlborn* And Interpretations Of The United States Department Of Health And Human Services	15
1. HHS Determinations Are Neither Entitled To Judicial Deference Nor Do They Conflict With *Ahlborn*	15
2. HHS's Interpretative Memorandia Is Not Entitled To *Chevron* Deference	18

TABLE OF CONTENTS – Continued

Page

C. Certiorari Is Not Appropriate Upon The Basis Of An Important Question Of Federal Law That Should Be Settled By This Court 18

1. This Case Does Not Present A Question Of Significant National Importance 19

2. *Ahlborn* Decision Does Not Misinterpret The Medicaid Law 21

CONCLUSION 23

TABLE OF AUTHORITIES

Page

FEDERAL CASES

Ahlborn v. Arkansas Dept. of Human Serv., 280 F.Supp.2d 881 (E.D. Ark. 2003) 2

Ahlborn v. Arkansas Dept. of Human Serv., 397 F.3d 620 (8th Cir. 2005) 2, 7, 8, 9, 16

Arkansas v. Farm Credit Serv. of Central Arkansas, 520 U.S. 821 (1997) 21

Badaracco v. Commissioner of Internal Revenue, 464 U.S. 386 (1984) 22

Chevron U.S.A. v. Natural Resources Defense Council, Inc., 467 U.S. 837 (1984) 3, 16, 17, 18

Christensen v. Harris County, 529 U.S. 576 (2000) 18

Cooper Indus. Inc. v. Aviall Serv., Inc., ___ U.S. ___, 125 S.Ct. 577 (2004) 18, 21, 22

Immigration & Naturalization Serv. v. St. Cyr, 533 U.S. 289 (2001) 16

Norwest Bank of North Dakota v. Doth, 159 F.3d 328 (8th Cir. 1998) 13

Oncale v. Sundowner Offshore Services, Inc., 523 U.S. 75 (1998) 22

Sullivan v. County of Suffolk, 174 F.3d 282 (2nd Cir. 1999), *cert. denied*, 528 U.S. 950 (1999) 12, 13

United States v. Craft, 535 U.S. 274 (2002) 7

Wisconsin Dept. of Health & Family Serv. v. Blumer, 534 U.S. 473 (2002) 17

TABLE OF AUTHORITIES – Continued

Page

STATE CASES

Calvanese v. Calvanese, 93 N.Y.2d 111, 688 N.Y.S. 2d 479, 710 N.E.2d 1079 (1999) 10, 12, 13

Cricchio v. Pennisi, 90 N.Y.2d 296, 660 N.Y.S.2d 679, 683 N.E.2d 301 (1997) 12

Gregory v. Colvin, 235 Ark. 1007, 363 S.W.2d 539 (1963) 6

Grey Bear v. North Dakota Dept. of Human Serv., 202 N.D. 139, 651 N.W.2d 611 (2002) 12, 13

Houghton v. Department of Health, 202 Ut. 101, 57 P.3d 1067 (2002), *cert. denied*, 538 U.S. 945 (2003) 11

Martin v. City of Rochester, 642 N.W.2d 1 (Minn. 2002), *cert. denied*, 539 U.S. 957 (2003) 14, 19

Wilson v. State, 142 Wash.2d 40, 10 P.3d 1061 (2000) 11

FEDERAL STATUTES

42 U.S.C. § 1396k(a)(1)(A) 7, 8, 12

42 U.S.C. § 1396a(a)(17)(B) 17

42 U.S.C. § 1396a(a)(25)(H) 7, 12

42 U.S.C. § 1396p(a)(1) ..... *passim*

STATE STATUTES

Ark. Code Ann. § 20-77-301 – § 20-77-313(2-3) 1

Ark. Code Ann. § 20-77-303 (Repl.2001) 20

Ark. Code Ann. § 20-77-307(a) 1

TABLE OF AUTHORITIES – Continued

Page

RULES OF THE SUPREME COURT OF THE UNITED STATES

Rule 10 15

Rule 19(a) 6

Rule 19(c) 6

STATEMENT OF THE CASE

Respondent Heidi Ahlborn (Ahlborn) sustained serious personal injuries in a motor vehicle accident, resulting in extensive medical treatment and significant permanent disability. She was determined to be eligible for Medicaid benefits which were provided by the Petitioner, Arkansas Department of Human Services (DHS), the state agency responsible for the administration of the Medicaid program. Arkansas law required Ahlborn to assign to DHS her "right to any settlement, judgment or award" that she might receive from responsible third parties "to the full extent of any amount which may be paid by Medicaid for the benefit of the applicant." Ark. Code Ann. § 20-77-307(a).

Ahlborn, by way of a compromise settlement, recovered $550,000.00 in insurance and tort claims. It was stipulated by DHS and Ahlborn that a reasonable value of her total claim, absent considerations of liability, was $3,040,708.12. (Petition App. 2) The components of her claim under Arkansas law included compensation for past and future medical care expenses, loss of earnings, impairment of earning capacity, pain and suffering, and permanent impairment disability. (Petition App. 17)

DHS provided Medicaid benefits on behalf of Ahlborn in the amount of $215,645.30 for which it asserted a lien against Ahlborn's settlement pursuant to Ark. Code Ann. § 20-77-301 – § 20-77-313(2-3). (Petition App. 18) Controversy developed between Ahlborn and DHS as to the permissible extent of the state's right of recoupment, which lead to the filing of this declaratory judgment action in the district court.

Ahlborn contended that 42 U.S.C. § 1396p(a)(1) (commonly referred to as the anti-lien statute) prohibits the imposition of a lien "against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the state plan[.]", and therefore DHS's statutory right of reimbursement was limited to that portion of the lump-sum settlement which fairly represented the past medical expense component of the recovery. The parties stipulated that if Ahlborn was correct DHS would be limited to recovering $35,581.47 (Petition App. 19), the amount of the percentage of the settlement fairly attributable to the past medical expense component of her claim.

DHS contended that, by reason of the statutory assignment, Ahlborn's claim in its entirety did not become her property until the Medicaid lien was satisfied and therefore there was no conflict with the anti-lien statute.

Before the district court, DHS and Ahlborn filed competing motions for summary judgment, upon which DHS prevailed. *Ahlborn v. Arkansas Dept. of Human Serv.*, 280 F.Supp.2d 881 (E.D. Ark. 2003). The Eighth Circuit Court of Appeals reversed the summary judgment and directed entry of judgment for the stipulated amount of the settlement attributable to the claim for medical expense. *Ahlborn v. Arkansas Dept. of Human Serv.*, 397 F.3d 620 (8th Cir. 2005). DHS now petitions this Court to issue a writ of certiorari to the Eighth Circuit Court of Appeals in order to review that decision.

SUMMARY OF ARGUMENT

DHS petitions this Court to issue a writ of certiorari in order to review *Ahlborn* first because of a supposed conflict between it and other federal and state court opinions. The conflict, however, that DHS advances is one of primarily differing end results rather than one of contrary interpretations of an issue of federal law. This federal law question is the extent to which 42 U.S.C. § 1396p(a)(1) (the anti-lien statute) limits the power of a state Medicaid program to appropriate the claim of, or proceeds from, a monetary recovery obtained by a Medicaid recipient from a third party tortfeasor. This precise issue of federal law was addressed by only two of the state cases, offered as conflicting decisions. In each of those, the analysis of the majority opinion of the court was superficial and premised upon faulty logic.

Rather than being a contrary interpretation of federal law, *Ahlborn* is entirely consistent with the only other reported decision based on an in-depth analysis of the statutory language. Because of the impaired precedent value of the judicial interpretations of the federal law question differing with *Ahlborn*, they should not be regarded as presenting a significant conflict. Accordingly, the conflict upon which DHS seeks issuance of certiorari is not substantial and does not rise to the level justifying a grant of certiorari.

DHS next contends that *Ahlborn* fails to give *Chevron* deference to administrative agency interpretations with which it is alleged to be in conflict. *Chevron* deference is not appropriate because there is no ambiguity in the statutory language. Absent ambiguity in the meaning of a statute, applying customary tools of interpretation, resort

to agency interpretations is neither required nor warranted. In any event, the administrative interpretations upon which DHS relies do not address the federal law question presented in *Ahlborn*. As is true with the majority of the judicial determinations, the conflicting interpretations of the anti-lien statute do not exist. Certiorari upon this basis is not appropriate.

A third basis upon which DHS seeks issuance of a writ of certiorari is the existence of an important question of federal law that should be settled by this Court. This contention assumes that there is something unsettled about the present statutory interpretations. This does not exist. The statutory language is, as found by the Eighth Circuit in *Ahlborn*, rather straightforward and is unambiguous in its meaning. *Ahlborn* provides a thorough analysis of the statutory language, and reaches the correct conclusion. Therefore, there does not exist an unsettled question of federal law which needs to be the subject of this Court's resources.

Contrary to DHS's assertion, the question resolved by *Ahlborn* is not of widespread significance. It arises only in those instances where a Medicaid recipient is, for any reason, unable to recover a substantial part of the medical expenses incurred by reason of an injury caused by tortious conduct. There is nothing in the record to suggest that this is a situation which arises with a frequency justifying this Court's involvement.

The final basis that DHS advances for the issuance of certiorari is the supposed effect upon the funding of the Medicaid program. Mechanics of funding of programs is not a function of the judiciary, but is a legislative matter. What DHS really takes issue with is not *Ahlborn* but the

decision of Congress, as to how the competing interests of the Medicaid program and the property rights of its beneficiary should be resolved. If the determination of Congress, embodied in the statutory language, is not desirable as a matter of policy, then it is for Congress to make that adjustment.

The core issue of DHS's petition is the assumption that *Ahlborn* was wrongly decided. This is a false assumption. *Ahlborn* is clearly a correct reading of the statutory language and reaches a result which those provisions clearly mandate. Whether the anti-lien statute is out of harmony with the overall scheme of the social legislation is not a matter of judicial concern. The only question is what does the clear statutory language mean in this context, which has been unequivocally and correctly answered in *Ahlborn* and therefore further judicial review is unnecessary.

ARGUMENT

Preface

A petition for the issuance of a writ of certiorari addresses the sound discretion of this Court. Because the judicial resources of any court are finite, and because of the sheer numbers of petitions for certiorari submitted to this Court, it has been recognized that "a writ of certiorari will be granted only for compelling reasons." Sup. Ct. R. 10. In order to identify those cases worthy of its review, the Court has identified certain criteria, articulated in Rule 10, two of which are relevant here to the reasons asserted in DHS's petition. The issuance of a writ of certiorari may be appropriate when a court of appeals' decision is in

conflict with another court of appeals' opinion on an important matter, where it conflicts with a state court decision on an important federal question, Sup. Ct. R. 19(a), or where a court of appeals' decision addresses an important question of federal law that has not been, but should be, settled by this Court. Sup. Ct. R. 19(c).

While all questions are important to the parties, there are few that rise to the level of importance that present the requisite compelling reasons for the granting of a writ of certiorari, all of which, for purposes of this case, turn upon two questions. First, is the precise issue of federal law in a state of uncertainty, either by reason of conflicting judicial interpretation of the statute in issue or because of the vagueness of statutory language, of a magnitude that requires it to be settled by this Court? Is this a question of federal law of widespread application or frequent recurrence, or is it an issue which arises only in narrow and limited circumstances?

Before turning to the specific arguments by DHS, an analysis of the issues, and of the Eighth Circuit's resolution of these, will be helpful. At the heart of the issue are competing interests of the Medicaid program's right of recoupment and the recipient's property interest. This conflict has been resolved by Congress in the statutes creating and defining the Medicaid program. By enactment of the anti-lien statute, 42 U.S.C. § 1396p(a)(1), Congress has prohibited the states from imposing liens upon the property of a living Medicaid recipient. The identification of what is "property" is not addressed by statute, but is by default left to state law to define. Here the applicable state law clearly holds that "the right to sue for damages is property," *Gregory v. Colvin*, 235 Ark. 1007, 1008, 363 S.W.2d 539, 540 (1963), as the Eighth Circuit

observed. *Ahlborn*, 397 F.3d at 624. Therefore, Ahlborn's claims arising out of her personal injuries were property to which the protection afforded by the anti-lien statute applies. Included within a claim arising out of a personal injury are a number of components, or elements which were identified in the district court opinion. (Petition App. 17) In terms of the common idiom which describes property as a "bundle of sticks", *e.g.*, *United States v. Craft*, 535 U.S. 274, 278 (2002), these elements of damage constitute the property interests created by the right to sue for damages. One of the sticks is the right to compensation for medical expenses.

Because of her personal injury, Ahlborn thereby acquired a property. By the enactment of the anti-lien statute, Congress has determined that the states should be precluded from seeking reimbursement from the property of a living recipient. As the Eighth Circuit held, the anti-lien statute "generally prevents a state from attaching property of a recipient to reimburse the state for benefits made under a Medicaid program." *Ahlborn*, 397 F.3d at 623. Thus, the general rule is that a living recipient's property is shielded from the state's right of reimbursement.

Congress, however, also mandated that the state's Medicaid plans must make provision for the acquisition of certain rights of the beneficiary to reimbursement, which provisions are obvious exceptions to the protection of the anti-lien statute. 42 U.S.C. § 1396a(a)(25)(H) requires that the state have in effect laws under which it is deemed to have acquired the rights of the recipient "to payment by the other party for such healthcare items and services." By 42 U.S.C. § 1396k(a)(1)(A), Congress mandated that the state require, as a condition of receiving benefits, assignment by

the recipient if "any rights . . . to payment for medical care from any third party." It is apparent, therefore, that an exception is created by these provisions, to the general protection afforded the "bundle" by the anti-lien statute. The scope of the exception to the general rule of protection, however, is limited by the express terms of the exception. Those terms limit the exception to only one stick; the "rights . . . to payment for medical care . . . " 42 U.S.C. § 1396k(a)(1)(A).

These statutory provisions were harmonized by the Eighth Circuit where it held:

> "We believe a straightforward interpretation of the test of these statutes demonstrates that the federal statutory scheme requires only the state recover payments from third parties to the extent of their legal liability to compensate the beneficiary *for medical and services* incurred by the beneficiary."

Ahlborn, 397 F.3d at 625. The Eighth Circuit then concluded that the Arkansas statutes that required an assignment of the entire cause of action against the third party tortfeasor to "conflict with and frustrate . . . [the] federal scheme." *Ahlborn*, 397 F.3d at 628.

As the Eighth Circuit correctly held, these statutory provisions clearly set forth a general rule of protection of the recipient's bundle coupled with an exception expressly limited to one stick. There is no uncertainty in the state of the law as regards the application of the anti-lien statute, 42 U.S.C. § 1396p(a)(1), in the context of tort claims of recipients. As the Eighth Circuit correctly observed in *Ahlborn*, the statutory language of the anti-lien statute, coupled with that of the provisions authorizing the state

Medicaid program to attach funds received as compensation for medical expenses, achieves a "harmonious scheme" of "plain meaning." *Ahlborn*, 397 F.3d at 626. Nor is there substantial uncertainty in decisional law, or administrative interpretations. The "conflict" authorities raised by DHS are clearly distinguishable since, as discussed *infra*, with two exceptions, none of these discuss the precise federal question presented here, *i.e.*, the application of the anti-lien statute. The two state cases that address this do so in a cursory manner which saps them of any significant precedent value upon this issue. Therefore, importance of this issue, in the sense of providing a compelling reason for certiorari, cannot be based upon a chaotic state of law.

Neither is this an issue of widespread significance. It arises only in instances of large damages where, as here, the recipient's ability to recover is significantly compromised by liability factors, lack of financial resources of the tortfeasor, or both. Unlike issues of eligibility of the recipient or coverages of specific services, which no doubt arise with daily frequency, the ramifications of the anti-lien statute in the context of third party recoveries is of a far more narrow nature.

The right of the Medicaid program to recoupment payments, made for medical benefits, and the property rights of its beneficiaries present an obvious case of competing interests. Congress has clearly resolved this conflict by clear statutory language correctly interpreted by the Eighth's Circuit's opinion in *Ahlborn*. There is, therefore, no compelling reason presented here for the issuance of a writ of certiorari.

A. Certiorari Is Not Appropriate Because Of Any Conflict Between *Ahlborn* And Other Decisions

A conflict *per se* between *Ahlborn* and other decisions does not of itself justify the issuance of a writ of certiorari. A more relevant question than whether there is a conflict of judicial opinions is that of the quality of the conflicting opinions, and the degree of uncertainty in the state of the federal law thus generated. While diametrically opposing results constitute a conflict, that should not create a state of uncertainty where one line of authority is based upon flawed logic, superficial consideration, or failure to give effect to statutory language of clear meaning. The existence of decisions opposing *Ahlborn* should not be a basis for review if an examination of the rationale of the conflicting decisions gives clear indication that they reach the wrong result and that *Ahlborn* represents the more fundamentally sound analysis of the statutory language. The mere existence of a scattering of inadequately reasoned opinions should not justify review of an unquestionably correct decision. The question of whether certiorari should be granted should turn on whether *Ahlborn* is correct.

1. The Utah And Washington Decisions Which Conflict With *Ahlborn* Are Fundamentally Unsound; The New York Case Does Not Address The Anti-Lien Statute

While DHS proclaims that *Ahlborn* is in conflict with decisions of New York, Utah and Washington which directly address the effect of the anti-lien statute, 42 U.S.C. § 1396(a)(1), (Petition 17), that is not entirely true. While the Utah and Washington decisions mention the anti-lien statute, the New York opinion on the scope of lien, *Calvanese v. Calvanese*, 93 N.Y.2d 111, 688 N.Y.S.2d

479, 710 N.E.2d 1079 (1999), did not consider the anti-lien statute, or the limitations it places upon the state's power to appropriate the Medicaid recipient's claim arising out of personal injuries. Therefore, only the Utah and Washington cases discussed below can be said to present a true conflict with *Ahlborn*.

The Utah decision, *Houghton v. Department of Health*, 2002 Ut. 101, 57 P.3d 1067 (2002), *cert. denied*, 538 U.S. 945 (2003), and the one from Washington, *Wilson v. State*, 142 Wash.2d 40, 10 P.3d 1061 (2000), all share the common analytical error of begging the question. In each of the decisions, the court's rationale assumed the validity of the state statutes which appropriated the entire claim of the Medicaid recipients who had been tortiously injured. The reasoning followed by each was that, by reason of statutory assignment, the state intercepted the claim between the tortfeasor and recipient before the claim or proceeds therefrom became the recipient's property, and therefore there was nothing for the anti-lien statute to protect.

This reasoning is patently fallacious. The question is not whether the state had effectively, by statute or other mechanism, appropriated the entire claim, but whether Congress had allowed this to be done. Rather than addressing the first question, that is, whether 42 U.S.C. § 1396p(a)(1) permitted the state to appropriate the entire claim by statute or other means, the courts assumed the validity of the appropriation. That, of course, is the question to be answered.

By assuming the validity of the preemptive strike against the recipient's entire cause of action, the courts failed to recognize, or at least give effect to, the statutory

limitations of 42 U.S.C. § 1396a(a)(25)(H) and § 1396k(a)(1)(A), both of which are limited to the recipient's right "to payment for any other party for such health care . . . " or "to payment for medical care." This is the only stick the state is allowed to take.

Because of the failure of these decisions to deal with the fundamental question, their precedent value is minimal. While they do conflict with *Ahlborn*, because of the flawed reasoning, as compared with the thorough analysis of the Eighth Circuit, the conflict is minimal. Rather than presenting a substantial conflict, these two decisions are more in the nature of bugs on the windshield.

Calvanese, as noted above, does not address the anti-lien statute. While it relies upon *Cricchio v. Pennisi*, 90 N.Y.2d 296, 660 N.Y.S.2d 679, 683 N.E.2d 301 (1997), which did address the anti-lien statute, it did so in the context of whether the state's right of recoupment could be circumvented by a transfer to a special-needs trust. *Cricchio* expressly left open the question of the scope of the state's right of recovery. *Cricchio*, 90 N.Y.2d at 309-310, 660 N.Y.S.2d at 684, 683 N.E.2d at 306. As a consequence, *Calvanese* does not present a true conflict with *Ahlborn* as regards the federal question; it is essentially a state statutory construction case.

2. *Ahlborn* Is Not In Conflict With The Second Circuit Decision Or That Of The North Dakota Court

While DHS asserts that *Ahlborn* is in conflict with the decision of the Second Circuit in *Sullivan v. County of Suffolk*, 174 F.3d 282 (2nd Cir. 1999), *cert. denied*, 528 U.S. 950 (1999), and of the North Dakota Court in *Grey Bear v.*

North Dakota Dept. of Human Serv., 2002 N.D. 139, 651 N.W.2d 611 (2002), the conflict is as the end result and not upon the federal law question presented by 42 U.S.C. § 1396p(a)(1). Neither opinion even mentions the anti-lien statute and accordingly does not present a conflict with *Ahlborn* on the federal law question.

Sullivan was, like *Norwest Bank of North Dakota v. Doth*, 159 F.3d 328 (8th Cir. 1998), and *Cricchio*, a case where the issue was whether the state's right of recoupment could be defected by a transfer of proceeds from the tortfeasor to a trust. The Second Circuit held that the Medicaid lien took precedence and therefore could not be avoided by this means. Actually, the state in *Sullivan* stipulated to a significant reduction in its lien and therefore the court refused to order a hearing on allocation. *Sullivan*, 174 F.3d at 286. As an aside by footnote in dictum, the court did say that the state lien extended to the entire claim, citing *Calvanese*, which did not consider the implications of the anti-lien statute. *Id.*, n.5. Therefore the footnoted dictum can hardly be said to conflict with *Ahlborn* on the federal law issue.

Grey Bear also failed to consider the limitations imposed by the anti-lien statute and in fact is only a state statutory construction case. It does not, therefore, present a conflict with *Ahlborn* on the federal statutory construction issue.

DHS acknowledges that the anti-lien statute was not raised in either *Sullivan* or *Grey Bear*, but argues that the "reasoning readily transfers to the anti-lien statute." (Petition 16) How the reasoning of a case that does not address the statutory language transfers to an interpretation of the meaning of the words is an unexplained mystery. What is

clear, however, is that these are not cases construing the same statute as *Ahlborn* and therefore do not present a conflict.

3. *Ahlborn* Is In Harmony With The Decisional Law Of The Minnesota Supreme Court

As DHS currently observes, *Ahlborn* is in total harmony with the decision of the Minnesota Supreme Court on the interpretation of the federal statutory provisions, *Martin v. City of Rochester*, 642 N.W.2d 1 (Minn. 2002), *cert. denied*, 539 U.S. 957 (2003). *Martin* is, in fact, the only decision other than *Ahlborn* which fully analyzes and harmonizes the statutory provisions reflecting Congress' balancing of the state's rights of recovery and the property rights of the Medicaid beneficiaries. The logic and analysis of the statutory language by both *Martin* and *Ahlborn* are impeccable. No doubt, a review by this Court will simply reaffirm the trenchant analysis of the Eighth Circuit in *Ahlborn* and therefore is entirely unnecessary.

4. Summary

Upon close examination, the conflict posited by DHS between *Ahlborn* and decisional law of other jurisdictions evaporates. Only two of the cases address the anti-lien statute, 42 U.S.C. § 1396p(a)(1), and therefore present a conflict on the federal question. The analyses of both are fatally flawed and therefore should not be deemed a substantial conflict justifying this Court's attention. The remaining cases do not address the statutory interpretation and therefore do not present a conflict at all. *Ahlborn* provides clear guidance to the interpretation of the statutory scheme which, although prolix, is stated unambiguously in

plain language. There is no uncertainty which this Court needs to settle.

B. Certiorari Is Not Appropriate Because Of Asserted Conflict Between *Ahlborn* and Interpretations Of The United States Department Of Health And Human Services

DHS seeks to justify a grant of certiorari because of a conflict it contends exists between *Ahlborn* and interpretations by the United States Department of Health and Human Services (HHS). A conflict between a decision of a United States Court of Appeals and an agency interpretation is not one of the considerations for review by certiorari enumerated in Rule 10 of the Court's Rules. In any event, the HHS interpretations upon which DHS relies, like some of the cases which have reached an inconsistent result, failed to take into account 42 U.S.C. § 1396p(a)(1) and its implications upon the scope of the state's rights of recovery and therefore do not present a conflict as to *Ahlborn* on the statutory interpretation issue. Furthermore, there is no ambiguity in the language of the applicable statutes and thus there is no need for the courts to look to an administrative agency to determine what the language means.

1. HHS Determinations Are Neither Entitled To Judicial Deference Nor Do They Conflict With *Ahlborn*

DHS contends that certiorari is appropriate because of the conflict between the position of *Ahlborn* and administrative interpretations by HHS. This contention, of course, argues that the Eighth Circuit did not give appropriate

deference to the administrative agency's determination. Contrary to this contention, the Eighth Circuit's opinion in *Ahlborn* is entirely consistent with this Court's definitive statement of the agency deference rule in *Chevron U.S.A. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984). There the Court unequivocally held that the administrative deference rule has no applicability when the statutory language is free from ambiguity. "If the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress." *Id.* at 842-43. More recently the Court held that "[w]e only defer, however, to agency interpretations of statutes that, applying the normal 'tools of statutory construction', are ambiguous." *Immigration & Naturalization Serv. v. St. Cyr*, 533 U.S. 289, 320 n.45 (2001).

In *Ahlborn*, the Eighth Circuit, using the normal tools of statutory construction, found there to be no ambiguity in the relevant statutes, and therefore deference to the agency interpretation was not appropriate. The Court held:

> "[T]he principles of deference apply only when a statute is ambiguous and the agency advances a reasonable interpretation of the statute. In this case, we reject the agency's interpretation as inconsistent with the plain language."

Ahlborn, 397 F.3d at 626.

Ahlborn is entirely consistent with the rule of *Chevron* and its progeny. By the plain language of the anti-lien statute and the statutes authorizing appropriation of the recipient's claim against a third party tortfeasor for expenses arising out of medical services, Congress has

clearly resolved the competing interests of the Medicaid program and its beneficiary. Having clearly stated its resolution by the statutory language, "that is the end of the matter." *Chevron*, 467 U.S. at 842. In this particular circumstance, Congress has not "explicitly left a gap for an agency to fill", *id.* at 843, but rather has spoken directly to the issue.

The agency interpretations upon which DHS predicates a conflict with *Ahlborn* are markedly different from those in issue in *Wisconsin Dept. of Health & Family Serv. v. Blumer*, 534 U.S. 473 (2002). In that case, the issue concerned the definition of available resources. Congress explicitly delegated authority to prescribe the appropriate standards for that determination to the administrative agency, by 42 U.S.C. § 1396a(a)(17)(B). *Blumer*, therefore, is an instance where Congress "explicitly left a gap for an agency to fill." *Chevron*, 467 U.S. at 843. By contrast, here Congress has, by unambiguous language, expressly delineated the scope of the state's authority to appropriate the recipient's property.

Even if it be assumed that *Chevron* deference should be given to the agency determinations, there still would be no conflict with *Ahlborn* since the two administrative adjudications exhibited with DHS's petition for certiorari do not consider 42 U.S.C. § 1396p(a)(1), and the limitations which it imposes. There is no conflict with *Ahlborn* since they do address the same issues. Both the California adjudication (Petition App. 68-86) and the later Washington matter (Petition App. 45-67) focus entirely upon the respective state's obligations to pursue recovery, but did not consider the limitations Congress has placed on those efforts by enactment of the anti-lien statute. Like some of the cases discussed, *supra*, only a part of the statutory

provisions was examined. Therefore, since the adjudications do not consider the statutory construction issue, upon which *Ahlborn* is based, there is no conflict, other than as to the end result. *Ahlborn* presents a complete statutory analysis which, for whatever reason, was not done in the agency adjudications.

2. HHS's Interpretative Memorandia Is Not Entitled To *Chevron* Deference

The other administrative materials submitted by DHS with its petition (Petitioner's App. 87-91) are interpretative memorandia which do not rise to the level required for *Chevron* deference. *See Christensen v. Harris County*, 529 U.S. 576 (2000). There the Court held:

> "Interpretations such as those in opinion letters – like interpretations contained in policy statements, agency manuals, and enforcement guidelines, all of which lack the force of law – do not warrant *Chevron*-like deference."

Id. at 587. The agency documents upon which DHS relies (Petition App. 87-91) are precisely the kind of writing which *Christensen* and the cases cited therein describe as not warranting deference under *Chevron*.

C. Certiorari Is Not Appropriate Upon The Basis Of An Important Question Of Federal Law That Should Be Settled By This Court.

DHS contends that *Ahlborn* presents an important question of federal law that should be settled by this Court. Implicit in that contention is the assumption that there is something unsettled about the state of law, with which *Ahlborn* takes exception. This question has long

since been settled by Congress, and the resources of this Court are not needed to stamp an imprimatur upon the plain meaning of the statutory language. As the opinion in *Ahlborn* ably demonstrates, the respective rights and liabilities of the Medicaid program and its beneficiaries, in the context of tort claim recoveries, have been clearly defined by Congress and therefore there is nothing that needs to be settled.

What DHS deems evidence of there being an unsettled question are the court decisions and administrative adjudications which have failed to consider the entire statutory scheme, including the anti-lien statute, or which are based upon faulty and incomplete analyses. There are two extant opinions which fully analyze the statutory language, *Ahlborn* and the earlier Minnesota decision in *Martin*. Rather than involving the Court at this point, the better course of action would be to see whether, in view of the guidance of the Eighth Circuit's thorough analysis in *Ahlborn*, a true conflict develops. If, over time, a number of courts, after studied analysis of the statutory language interpreted by *Ahlborn*, reach a different conclusion, then perhaps a resolution by this Court is warranted. At this time, it is not.

1. This Case Does Not Present A Question Of Significant National Importance

DHS justifies its characterization of the question as being important, in part, because of funding needs. (Petition 27) The funding of Medicaid, or any other program, is not, however, a judicial function. It is a function of the courts to interpret the statutes and not to enact or amend them. If this is truly the important issue that DHS contends it to be,

and if Congress agrees that its present balancing of the competing interests of the Medicaid programs and the property rights of its beneficiaries are inappropriate, then it may amend the statutes.

DHS contends that its position makes perfect sense. (Petition, 28) Like beauty, what makes perfect sense is a matter of one's perspective. While subsidizing the Medicaid program by seizing upon the recipient's property understandably makes perfect sense to DHS, quite the contrary is true when viewed from the recipient's viewpoint. If the legislative objective was to maximize the filling of Medicaid's coffers, at the expense of the recipients, then one must wonder why Congress determined that a general rule against levies upon recipients' property, as embodied in the anti-lien statute, should be enacted.

What does make perfect sense, that is what has a degree of symmetry, is the statutory scheme as interpreted by the Eighth Circuit in *Ahlborn*. Medicaid pays for medical services required by reason of injury caused by tortious conduct. To the extent the injured party is able to extract a recovery of those expenses, Medicaid gets paid back. This is the scheme that would appear to make perfect sense, more so than the position advocated by DHS. In some cases, the position taken by DHS would mean that the tort victim's claim would inure only to the benefit of DHS and the victim's lawyers, an end result entirely possible under the Arkansas statute. *See* Ark. Code Ann. § 20-77-303 (Repl.2001).

Ahlborn is applicable only in those limited circumstances where, because of liability considerations, lack of sufficient insurance coverage upon or financial resources of the tortfeasor, the recovery upon the medical expense

component of the recipient's claim is not sufficient to cover the Medicaid lien. Because of the limited instances where this will arise and, in view of the well-reasoned construction of the statute by the Eighth Circuit, this is not a question of that degree of importance that merits this Court's review.

2. *Ahlborn* Decision Does Not Misinterpret The Medicaid Law

DHS argues that the Eighth Circuit in *Ahlborn* misinterpreted the federal Medicaid law because it is perceived to be inconsistent with the generalized payer of last resort concept. Statutes, however, must be interpreted and given effect according to the plain import of the statutory language. It is not appropriate to disregard specific statutory language because of a perceived inconsonance with a generalized theme. The goal of statutory interpretation is to determine legislative intent based upon obvious meaning of statutory language, and it gives the statute its intended effect. As the Court has held, "it is a basic principle that statutory language is to be enforced according to its terms." *Arkansas v. Farm Credit Serv. of Central Arkansas*, 520 U.S.821, 827 (1997).

Where statutory provisions are clearly and unambiguously stated, that ends the matter. It is not appropriate to torture the language of specific statutory provisions in the name of some generalized purpose of a larger legislative scheme. The argument advanced here by DHS was put before the Court in the context of another comprehensive statutory enactment in *Cooper Indus. Inc. v. Aviall Serv., Inc.*, ___ U.S. ___, 125 S.Ct. 577 (2004). In rejecting this argument, the Court held in language apropos here:

> "Given the clear meaning of the text there is no need to resolve this dispute or to consult the purpose of CERCLA at all. As we have said: '[I]t is ultimately the provisions of our laws rather than the principal concerns of our legislators by which we are governed.' *Oncale v. Sundowner Offshore Services, Inc.*, 523 U.S. 75 . . . (1998)."

Cooper at 125 S.Ct. 584.

While facially DHS assails the well-reasoned opinion of the Eighth Circuit in *Ahlborn*, what it really seeks is a judicial rewriting of the statutory language. *Ahlborn* is the messenger, not the message. Courts, however, interpret and apply statutes rather than rewriting them. An appropriate answer to DHS's position is set forth in *Badaracco v. Commissioner of Internal Revenue*, 464 U.S. 386, 398 (1984), where the Court stated:

> "Courts are not authorized to rewrite a statute because they might deem its effects susceptible of improvement."

Ahlborn correctly interprets and applies the anti-lien statute and those accompanying statutes providing an exception thereto in the context of recoupment of benefits from the proceeds of a claim for medical expenses against a tortfeasor or other liable party. The analysis of the Eighth Circuit of the statutory provision is well reasoned and reaches the result mandated by the plain meaning of the statutory language. Therefore, certiorari is not justified to review a fundamentally sound decision.

CONCLUSION

There is no basis for the issuance of a writ of certiorari for review of the Eighth Circuit's decision in *Ahlborn*. The significance of the conflict between *Ahlborn* and other cases and agency interpretations asserted by DHS evaporates upon close examination. That conflict is largely as to results, which is not the relevant inquiry. This Court is not concerned with the ultimate results. It is whether there are different interpretations of an issue of federal law that determines whether the issuance of a writ of certiorari in order to resolve the question is warranted. The federal law issue is the application of the anti-lien statute in the context of a Medicaid recipient's tort recovery.

Of the purported conflicting authority, this federal law question has been addressed by only two state cases, the analyses of which are both cursory and flawed to the point that, as to this issue, these decisions present only a *de minimis* conflict.

Implicit in DHS's position is the suggestion that the anti-lien statute is antithetical to the Medicaid program in the context of personal injury recoveries. If that is the case, it is a matter for Congress, not the Court, to address.

DHS asserts that *Ahlborn* was wrongly decided, which is not accurate. In the *Ahlborn* opinion, the Eighth Circuit carefully examined the statutory language and reached the conclusion which it clearly mandates. *Ahlborn* and the Minnesota case are the only extant definitive analyses of the federal law issue presented by the anti-lien statute, both of which reached the right conclusion. Further review is, therefore, not needed.

Ahlborn respectfully submits that the petition for writ of certiorari to the Eighth Circuit should be denied.

Respectfully submitted,

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No. 04-1506

NOV 22 2005

In The Supreme Court of the United States

ARKANSAS DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,

Petitioners,

v.

HEIDI AHLBORN,

Respondent.

On Writ Of Certiorari To The United States Court Of Appeals For The Eighth Circuit

JOINT APPENDIX

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Certiorari Granted September 27, 2005

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INDEX

Page

Chronological List of Relevant Docket Entries 1

Plaintiff's Complaint, Filed September 30, 2002..... 3

Defendants' Answer, Filed October 18, 2002 10

Stipulation, Filed February 18, 2003..... 17

Defendants' Statement of Material Facts, Filed March 6, 2003 21

Memorandum in Support of Defendants' Motion for Summary Judgment, Filed March 6, 2003 26

Exhibit 3, HCFA letter entitled "State Third Party Liability ("TPL") Subrogation Legislation (issued June 1, 1988) with attachment entitled "To The Reader of 'Third Party Liability In The Medicaid Program: A Guide To Successful State Agency Practices,' Notice Of Errata" 27

Exhibit 21, HCFA Memorandum to State Medicaid Directors entitled "Third Party Liability Relationship to Issue Of Liens" (issued September 2, 1994)..... 31

Exhibit 22, HCFA letter entitled "Treating Disability Trusts Under Transfer Of Assets, Trust, Estate Recovery, and Third Party Liability Rules – INFORMATION" (issued June 6, 1996) 34

Plaintiff's Response to Defendants' Statement of Material Facts and Plaintiff's Statement of Material Facts, Filed April 17, 2003 42

Defendants' Response to Plaintiffs' Statement of Material Facts, Filed April 23, 2003 46

INDEX – Continued

Page

The following opinions, judgments, and orders, have been omitted in printing this joint appendix because they appear on the following pages in the appendix to the Petition for Certiorari:

Order and Judgment of the United States District Court for the Eastern District of Arkansas, entered August 25, 2003.....App. 16

Opinion of the United States Court of Appeals for the Eighth Circuit, entered February 9, 2005.....App. 1

CHRONOLOGICAL LIST OF RELEVANT DOCKET ENTRIES

September 30, 2002 – Plaintiff's complaint filed in the United States District Court for the Eastern District of Arkansas, Western Division.

October 18, 2002 – Defendants' answer filed.

February 18, 2003 – Stipulation filed jointly by plaintiff and defendants.

March 6, 2003 – Defendants' motion for summary judgment filed.

March 6, 2003 – Defendants' memorandum in support of motion for summary judgment filed.

March 6, 2003 – Defendants' statement of material facts filed.

April 17, 2003 – Plaintiff's response to defendants' motion for summary judgment, as well as cross motion for summary judgment, filed.

April 17, 2003 – Plaintiff's memorandum brief in support of motion for summary judgment and cross motion for summary judgment filed.

April 17, 2003 – Plaintiff's response to defendants' statement of material facts, as well as plaintiff's statement of material facts, filed by plaintiff.

April 23, 2003 – Defendants' response to plaintiff's cross motion for summary judgment filed.

April 23, 2003 – Defendants' memorandum in support of response to plaintiff's cross motion for summary judgment filed.

April 23, 2003 – Defendants' response to plaintiff's statement of material facts filed.

August 25, 2003 – Order and Judgment of the district court entered, granting defendants' motion for summary judgment and denying plaintiff's cross motion for summary judgment.

September 18, 2003 – Plaintiff's notice of appeal filed.

March 14, 2005 – Opinion and Judgment of the United States Court of Appeals for the Eighth Circuit entered, reversing the district court and remanding case with directions to enter judgment in favor of defendants in amount of $35,581.47.

May 9, 2005 – Petition for Writ of Certiorari filed by defendants/petitioners.

IN THE UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF ARKANSAS
WESTERN DIVISION

HEIDI AHLBORN, Plaintiff VS. ARKANSAS DEPARTMENT OF HUMAN SERVICES; DIRECTOR OF THE ARKANSAS DEPARTMENT OF HUMAN SERVICES; AND DIRECTOR OF THE THIRD PARTY LIABILITY UNIT, DIVISION OF MEDICAL SERVICES OF THE ARKANSAS DEPARTMENT OF HUMAN SERVICES, Defendants	CASE NO. 4-02.CV.00607GTE This case assigned to District Judge Eisele and to Magistrate Judge Jones

COMPLAINT

(Filed Sep. 30, 2002)

Comes Heidi Ahlborn, Plaintiff herein, and for her claim against Arkansas Department of Human Services (hereinafter referred to as "Department"); the Director of the Arkansas Department of Human Services (hereinafter referred to as "Director"); and Director of the Third Party Liability Unit, Division of Medical Services of the Arkansas Department of Human Services (hereinafter referred to as "Division Director"), states:

1. Plaintiff is a citizen of the State of Arkansas. Defendant Department is a department of the Arkansas state government charged with the responsibility of administering the Medicaid program. Defendant Director

is the state administrative official charged with administration of Defendant Department. Defendant Division Director is the state official within the Defendant Department charged with the responsibility of administering and enforcing liens or other rights by reason of payments made to or on behalf of Medicaid beneficiaries. Defendants all reside within the Eastern District of Arkansas. Plaintiffs claims herein for injunctive and declaratory relief involve assertion of rights under the laws of the United States, specifically 41 U.S.C. § 1396p and 42 U.S.C. § 1983. Jurisdiction of Plaintiff's claims herein is pursuant to 28 U.S.C. § 1331.

2. On January 2, 1996, Plaintiff sustained a serious injury in a motor vehicle accident in Sharp County, Arkansas. As a result of those injuries, Plaintiff required extensive medical treatment. During the time of her treatment, Plaintiff qualified for medical benefits under the Medicaid program, administered within the State of Arkansas by Defendant Department. Defendant Department provided Medicaid benefits to or on behalf of Plaintiff in the amount of $219,156.78.

3. Plaintiff has previously made claims against others for damages arising out of injuries she received in the occurrence on January 2, 1996, which claims resulted in compromise settlements totaling $550,000.00 of which $25,000.00 was paid by Plaintiff's own insurance company pursuant to her underinsured motorist coverage. Plaintiff sustained serious permanent personal injuries as a result of the occurrence, fair compensation for which greatly exceeded the amount of the compromise settlement, which amount was greatly influenced by serious issues of liability and monetary limitations of some of the insurance policies involved. These sums were paid in full and complete

settlement of all claims of any nature, whether past or future, arising out of her injuries in this occurrence.

4. Defendant Division Director has, pursuant to Ark. Code Ann. § 20-77-301, *et seq.*, asserted a claim or lien in the amount of $219,156.78 against the funds Plaintiff received as a result of the above-described settlement. Plaintiff's attorneys are holding, in a trust account, the sum of $219,156.78 pending resolution of the claims and request for relief asserted herein.

5. The above-described funds, presently held by Plaintiff's attorneys in trust, for Plaintiff's benefit, constitute Plaintiff's property as to which Defendant Division Director asserts a lien and a claim for payment.

6. There exists a genuine controversy between Plaintiff and Defendants as to extent of Defendants' right of repayment from property owned by Plaintiff and the extent to which Ark. Code Ann. § 20-77-301, *et seq.*, as applied to Plaintiff's property hereinabove described, is preempted by 42 U.S.C. § 1396p(a) and whether Defendants' assertion of a lien against Plaintiff's property, under color of state law, deprives Plaintiff of a right under 42 U.S.C. § 1396p(a) and therefore is in violation of 42 U.S.C. § 1983. Plaintiff therefore requests declaratory relief, pursuant to 28 U.S.C. § 2201, declaring the respective rights of the parties as regards these funds and construing and determining the extent to which Ark. Code Ann. § 20-77-301, *et seq.*, may be applied to these funds, under the supremacy clause, Article VI, United States Constitution.

7. 42 U.S.C. § 1396p(a)(1) provides:

> "No lien may be imposed against the property of any individual prior to his death on a count of medical assistance paid or to be paid on his behalf under the state plan, except. . . . "

None of the exceptions to this provision are applicable here. The lien claimed by Defendants against Plaintiff's property arises out of medical assistance paid under a state plan.

8. As a direct result of the motor vehicle accident on January 1, 1996, Plaintiff sustained severe personal injuries, the most significant of which was a closed-head injury which caused permanent brain damage. As a direct result of these injuries, Plaintiff incurred medical expenses in addition to those provided by Defendant and has sustained in the past and will sustain in the future pain, suffering and mental anguish; will incur medical expenses in the future for which Defendant will not be responsible; has sustained a loss of earnings in the past and a past and future permanent loss of earning capacity; and has sustained a significant permanent disability. Plaintiff was, at the time of her injury, 19 years of age with a future statistical life expectancy of 59.02 years. Plaintiff's damages, as a result of these injuries, exceed, by many fold, the total sum realized from all sources ($550,000.00), $25,000.00 of which was from Plaintiff's own insurance coverage which should be excluded from consideration.

9. Plaintiff's right to compensation for each of these elements of damage, recognized under Arkansas law, constitutes a separate property interests of Plaintiff.

10. Ark. Code Ann. § 20-77-307, upon its face, provides for an assignment to Defendant Department of

all claims arising out of her injury. To the extent that such assignment extends to Plaintiff's claim for elements of damage for other than past medical expenses, the assignment and lien created by Ark. Code Ann. § 20-77-307 is a direct violation of Plaintiff's rights under 42 U.S.C. § 1396p(a)(1), as constituting a lien upon Plaintiff's property, and is therefore, to that extent, invalid by reason of the supremacy clause.

11. To the extent that Ark. Code Ann. § 20-77-307 creates a lien upon Plaintiff's claim for compensation other than for medical expenses, it deprives Plaintiff of a right created by 42 U.S.C. § 1396p(a)(1) and therefore is in violation of 42 U.S.C. § 1983.

12. Plaintiff requests that the Court adjudicate, by way of a declaratory judgment, that the rights of Defendant Department, pursuant to Ark. Code Ann. § 20-77-301, *et seq.*, including but not limited to 20-77-307, to the extent it seeks to reach that portion of Plaintiff's settlement other than that attributable to medical expenses furnished by Defendant Department, constitutes an impermissible lien, upon Plaintiff's property, in violation of 42 U.S.C. § 1396p(a)(4) and, to such extent, deprives Plaintiff of a right created by the laws of the United States, in violation of 42 U.S.C. § 1983. Accordingly Plaintiff requests that the Court adjudicate and declare such statute to be invalid, under the supremacy clause, to that extent.

13. Plaintiff further requests that the Court adjudicate and declare, by way of a declaratory judgment, that the proceeds from the underinsured motorist coverage, be excluded from computations requested herein.

14. Plaintiff further requests that the Court determine, by way of a declaratory judgment, the extent to which the settlement proceeds of $525,000.00, excluding underinsured motorist benefits, are attributable to past medical expenses furnished by Defendant Department and that the Court further adjudicate and declare, by way of a declaratory judgment, that the lien or right of recovery of Defendant Department is limited to that portion of the settlement adjudicated to be attributable to these past medical expenses.

15. Plaintiff further requests that Defendant Director and Defendant Division Director be permanently enjoined from seeking to impose a lien pursuant to Ark. Code Ann. § 20-77-307, and be enjoined from instituting any action pursuant to Ark. Code Ann. § 20-77-305, beyond seeking recovery of that portion of Plaintiff's settlement, excluding underinsured motorist coverage, adjudicated herein to be that attributable to Plaintiff's past medical expenses furnished by Defendant Department.

WHEREFORE, Heidi Ahlborn, Plaintiff herein, demands declaratory and injunctive relief against Defendants and each of them, as hereinabove set forth and that Plaintiff be granted all further relief which the Court deems just and proper including recover of costs and attorney fees, pursuant to 42 U.S.C. § 1988(b).

HEIDI AHLBORN

Plaintiff

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IN THE UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF ARKANSAS
WESTERN DIVISION

HEIDI AHLBORN, Plaintiff VS. ARKANSAS DEPARTMENT OF HUMAN SERVICES; DIRECTOR OF THE ARKANSAS DEPARTMENT OF HUMAN SERVICES; AND DIRECTOR OF THE THIRD PARTY LIABILITY UNIT, DIVISION OF MEDICAL SERVICES OF THE ARKANSAS DEPARTMENT OF HUMAN SERVICES, Defendants	)	CASE NO. 4-02-CV.00607GTE

ANSWER

(Filed Oct. 18, 2002)

The defendants, Arkansas Department of Human Services, Director of the Arkansas Department of Human Services, and Director of the Third Party Liability Unit, Division of Medical Services of the Department of Human Services, and for their answer to the complaint, state as follows:

1. Admits plaintiff is a citizen of the State of Arkansas. Admits the Department of Human Services (Department) is a department within the Executive Branch of the Arkansas State government. Affirmatively pleads that the Department enjoys sovereign immunity and is not a proper party. Admits that the Director of the Department

is Kurt Knickrehm. Further admits that Mr. Knickrehm is the officer responsible for operations within the Department. Admits that Ray Hanley is the Director of the Division of Medical Services (DMS) within the Department. Further admits that Mr. Hanley has general oversight responsibility for the operations of the DMS. Further admits that Mr. Wayne E. Olive is the DMS Program Administrator, responsible for operation of the Third Party Liability Unit within DMS. Admits the parties reside in the Eastern District of Arkansas. The remaining allegations of paragraph 1 of the complaint do not set facts to which response is necessary, however, to the extent response is required same are denied.

2. Admits that plaintiff sustained an injury and required medical treatment. Admits that some or all of the costs of medical treatment were paid through the Arkansas Medicaid Program. Further admits that the Arkansas Medicaid Program has paid at least $215,645.30. The amount in dispute continues to increase as plaintiff receives additional health care services related to the accident. The $215,645.30 paid by the Arkansas Medicaid Program satisfied bill charges of $320,642.18. Pursuant to federal and state law plaintiff has no obligation to satisfy the unpaid balance. Plaintiff remains eligible for benefits furnished under the Arkansas Medicaid Program and defendants reasonably anticipate that additional charges will be incurred and paid by the Arkansas Medicaid Program.

3. Defendants admit that plaintiff has settled various claims against third parties liable for the injuries sustained by plaintiff. At the time plaintiff entered into the settlement plaintiff was aware of the payments made by the Arkansas Medicaid Program but plaintiff failed to

afford the Arkansas Medicaid Program notice of the settlement negotiations or proceedings. Despite plaintiff's prior assignment of rights in favor of the Arkansas Medicaid Program and despite actual notice of payments made by the Arkansas Medicaid Program, plaintiff failed to afford defendants notice of settlement proceedings and effectively foreclosed defendants from asserting their interest directly to the third parties liable for plaintiff's injuries. Plaintiff, by entering into a full and complete settlement of all claims of any nature, whether past or future, arising out of her injuries, is estopped to deny the adequacy of the settlement and is estopped to deny full reimbursement to the Arkansas Medicaid Program.

4. Defendants admit that, pursuant to 42 U.S.C. § 1396a(a) (25) (H) and state enabling legislation found codified at Ark. Code Ann. §§ 20-77-301 *et seq.*, the Arkansas Medicaid Program has asserted an interest in the settlement. The value of the interest is at least $215,645.30 and defendants respectfully reserve the right to amend the value to reflect additional payments made on behalf of plaintiff. Defendants affirmatively state that plaintiff knew of the interest of the Arkansas Medicaid Program at the time she entered into a full and complete settlement of all claims of any nature, whether past or future, arising out of her injuries. Defendants further affirmatively state that plaintiff is estopped to deny the interest of the Arkansas Medicaid Program. Defendants further acknowledge the plaintiff's attorneys have assured defendants that the sum of $219,156.78 is being held in a trust account pending resolution of this dispute.

5. Defendants deny that the funds in dispute constitute plaintiff's property. Defendants affirmatively state that the plaintiff has assigned her interest in the funds to

the Arkansas Medicaid Program, and that she is holding the disputed funds for constructive trust in favor of the Arkansas Medicaid Program.

6. Defendants deny all factual allegations contained in paragraph 6 of the complaint. Defendants further deny plaintiff's characterization of law contained in paragraph 6 of the complaint. Defendants deny this court has jurisdiction.

7. Paragraph 7 of the complaint sets forth excerpts of federal law and does not assert to which response is necessary, however, to the extent response is deemed necessary, same are denied.

8. Defendants admit that plaintiff suffered injuries on or about January 1, 1996. Defendants deny the remaining allegations of paragraph 8 of the complaint.

9. Defendants deny the allegations of paragraph 9 of the complaint.

10. Paragraph 10 of the complaint contains no allegation of fact to which response is required, however, to the extent response is deemed necessary, same are denied. Defendants affirmatively state that 42 U.S.C. § 1396a(a)(25)(H) mandates the enactment of Ark. Code Ann. §§ 20-77-301 *et seq.*

11. Paragraph 11 of the complaint contains no allegation of fact to which response is required, however to the extent response is deemed necessary, same are denied. Defendants affirmatively plead that Ark. Code Ann. §§ 20-77-301 *et seq.* was enacted as required by 42 U.S.C. § 1396a(a)(25)(H).

12. Paragraph 12 of the complaint does not allege facts to which response is required, however, to the extent response is deemed necessary, same are denied. Defendants affirmatively state that Ark. Code Ann. §§ 20-77-301 *et seq.* was enacted as required by 42 U.S.C. § 1396a(a)(25)(H). Defendants expressly deny that 42 U.S.C. § 1396p(a)(4) is applicable to this dispute.

13. Defendants deny that the underinsured motorist coverage should be excluded from any computations herein. Underinsured motorist coverage is a third party payer within the meaning of 42 C.F.R. § 433.136. Alternatively pleading, if the $25,000.00 underinsured motorist coverage is plaintiff's property she had, at all times relevant hereto, resources in excess of the $2,000.00 resource limit. The excess resources render plaintiff, at all times relevant hereto, ineligible for benefits administered by the Arkansas Medicaid Program. If she was ineligible she is not a Medicaid recipient. It she is not a Medicaid recipient the provisions of 42 U.S.C. § 1396p(a)(4) do not apply. If she is ineligible all payments by the Arkansas Medicaid Program were made in error. Permitting plaintiff to benefit from erroneous payments made in good faith by the Arkansas Medicaid Program results in an unjust enrichment to plaintiff. Moreover, if plaintiff was at all times ineligible for benefits, the Arkansas Medicaid Program has an absolute right to recover all erroneous payments made on behalf of plaintiff. The total amount paid by Medicaid is $218,940.19 and increases as plaintiff receives additional health care services.

14. Paragraph 14 is in the nature of a prayer for relief and contains no allegations of facts to which response is required, however, to the extent response is deemed necessary same are denied. Defendants affirmatively plead that

plaintiff, having negotiated a full and complete settlement of all claims of any nature, whether past or present, arising out of the injuries without notice of settlement proceedings to defendants is estopped to deny reimbursement of at least $215,645.30 to the Arkansas Medicaid Program. Defendants further affirmatively plead that the funds at issue are being held in constructive trust for the Arkansas Medicaid Program.

15. Paragraph 15 is in the nature of a prayer for relief and contains no allegations of facts to which response is required, however, to the extent response is deemed necessary same are denied. Defendants affirmatively plead that plaintiff, having negotiated a full and complete settlement of all claims of any nature, whether past or present arising out of the injuries without notice of settlement proceedings to defendants is estopped to deny reimbursement of at least $215,645.30 to the Arkansas Medicaid Program. Defendants further affirmatively plead that the funds at issue are being held in constructive trust for the Arkansas Medicaid Program.

WHEREFORE, defendants pray that the Court enter its order dismissing the complaint and directing plaintiff to reimburse the Arkansas Medicaid Program full reimbursement of expenditures made on behalf of Heidi Ahlborn.

Respectfully submitted,

ARKANSAS DEPARTMENT
OF HUMAN SERVICES
OFFICE OF CHIEF COUNSEL

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IN THE UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF ARKANSAS
WESTERN DIVISION

HEIDI AHLBORN, Plaintiff	)	
VS.	)	CASE NO.
ARKANSAS DEPARTMENT OF HUMAN SERVICES; ET AL, Defendants	)	4:02CV00607 GTE

STIPULATION

Come Heidi Ahlborn, Plaintiff herein, and Arkansas Department of Human Services; the Director of the Arkansas Department of Human Services; and Director of the Third Party Liability Unit, Division of Medical Services of the Arkansas Department of Human Services, Defendants, and who hereby stipulate as follows:

1. Plaintiff contends that Defendants' rights, pursuant to Ark. Code Ann. § 20-77-301, *et seq.*, are, by virtue of the constitutional supremacy clause, limited by 42 U.S.C. § 1396p(a)(1), as a consequence of which Defendants' rights of subrogation or reimbursement, by reason of Medicaid benefits provided to or on behalf of Plaintiff, are limited to that portion of Plaintiff's recovery in a previous third party tort action which represents the past medical expense component of her recovery. Defendants contend that, pursuant to 42 U.S.C. §1396a(a)(25), as implemented by Ark. Code Ann. §20-77-301 *et seq.*, they are entitled to reimbursement from the proceeds of the aforesaid settlement in the amount of $216,645.30, that being the amount

of Medicaid benefits provided to on or behalf of Heidi Ahlborn as of the date of the settlement of the third party action. For purposes of this stipulation, these competing contentions are designated as the "statutory construction issue."

2. Plaintiff negotiated a settlement of her claims. The gross amount of the settlement is $550,000.00 as follows: (a) $25,000.00 from Plaintiff's underinsured motorist coverage; (b) $525,000.00 from third party tortfeasors. The settlement did not designate portions of the damages for medical and non-medical damages. Plaintiff contends that, as a matter of law, the uninsured motorist coverage is not subject to Defendants' claim for reimbursement. Defendants contend that, as a matter of law, all sources of recovery are available for reimbursement.

3. It is stipulated that Plaintiff prepared and intended to submit a reasonable estimation of the value of Plaintiff's third party tort claim to the jury. The proposed estimation of damages, absent any consideration of liability, describes Plaintiff's damages as approximately $3,040,708.12. The settlement represents approximately one-sixth (1/6) or 16.5% of the estimated value of damages. Therefore, the parties agree, in the event Plaintiff prevails on the statutory construction issue, that Defendant shall be reimbursed and paid from funds held in trust by Plaintiff's attorneys, pending a resolution of this issue, 16.5% of past Medicaid payments, or $35,581.47 in full satisfaction of Medicaid's right of reimbursement.

In the event Defendants prevail upon the statutory construction issue, it is stipulated and agreed that Defendants shall be entitled to reimbursement from the aforesaid funds the sum of $215,645.30.

It is agreed that this stipulation is entered into by Plaintiff and Defendants for the sole purpose of obviating the necessity of adducing evidence as to the reasonable value of Plaintiff's third party tort claim and this stipulation shall in no way affect the relative positions of the parties as regards the statutory construction issue, nor shall this stipulation in any way affect the parties' rights of appeal from the statutory construction issue as determined by the final judgment entered herein.

Dated this 13th day of February, 2003.

HEIDI AHLBORN

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IN THE UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF ARKANSAS
WESTERN DIVISION

HEIDI AHLBORN, Plaintiff VS. ARKANSAS DEPARTMENT OF HUMAN SERVICES; DIRECTOR OF THE ARKANSAS DEPARTMENT OF HUMAN SERVICES; AND DIRECTOR OF THE THIRD PARTY LIABILITY UNIT, DIVISION OF MEDICAL SERVICES OF THE ARKANSAS DEPARTMENT OF HUMAN SERVICES Defendants	)	CASE NO. 4-02-CV. 00607 GTE

DEFENDANTS' STATEMENT OF MATERIAL FACTS

(Filed Mar 06, 2003)

Defendants, pursuant to FRCR Rule 56 and Local Rule 56.1, submits the following statement of the material facts to which they contend there is no genuine issue to be tried:

1. Plaintiff, Heidi Ahlborn, is an individual residing in the State of Arkansas.

2. Defendant, Arkansas Department of Human Services (ADHS) is an agency within the Executive Branch of Government for the State of Arkansas. Defendant, Kurt Knickrehm is the Director of ADHS. Defendant

Roy Jeffus is the Interim Director of the ADHS, Division of Medical Services (DMS). Defendant, Wayne E. Olive is the Administrator, ADHS/DMS Third Party Liability Unit.

3. ADHS administers the Medicaid program for the State of Arkansas.

4. On or about January 2, 1996 plaintiff was injured in a motor vehicle accident. Plaintiff, 19 years old at the time of the accident, sustained injuries and needed medical care.

5. Plaintiff applied to receive Medicaid through ADHS.

6. ADHS approved plaintiff's application for Medicaid.

7. Plaintiff also applied to the Social Security Administration to receive Supplemental Security Income (SSI). SSI recipients also receive Medicaid benefits from ADHS.

8. Plaintiff notified medical care providers to submit accident related claims to ADHS.

9. ADHS received, processed and paid claims for accident related medical services.

10. The amount billed to ADHS for accident related services is approximately $320,000.00. ADHS paid health care providers $215,645.30. Payment by ADHS fully extinguished plaintiff's financial obligation.

11. On or about May 23, 1996 ADHS sent a questionnaire to plaintiff. Plaintiff returned the questionnaire and informed ADHS she had engaged an attorney, John Casteel.

12. On or about July 17, 1996 ADHS wrote to Mr. Casteel. The correspondence included an itemization of charges paid by Medicaid.

13. On or about January 6, 1997 ADHS wrote to Mr. Casteel and provided an updated itemization of charges paid by Medicaid.

14. On or about April 11, 1997 plaintiff, through Mr. Casteel, filed a personal injury claim in the Circuit Court of Independence County, Arkansas.

15. Plaintiff did not name ADHS a party to the proceeding and Mr. Casteel did not serve notice or pleadings on ADHS.

16. On or about July 29, 1997 Mr. Casteel telephoned ADHS and requested a waiver of the Medicaid claim. Mr. Casteel informed ADHS of a $25,000.00 policy limits recovery.

17. ADHS denied the request for a waiver of the Medicaid claim.

18. On or about September 8, 1997 Mr. Casteel made a second verbal request for a waiver of the Medicaid claim. ADHS directed Mr. Casteel to submit a written request.

19. On or about September 8, 1997 plaintiff, through Mr. Casteel submitted a written request for a waiver of the Medicaid claim. The request was not granted.

20. On or about December 23, 1997 plaintiff's present counsel wrote ADHS concerning a $25,000.00 underinsured motorist (UIM) coverage recovery. Plaintiff asserted the UIM coverage was not subject to the Medicaid claim.

21. On or about December 29, 1997 ADHS responded, voicing disagreement with plaintiff's assertion UIM coverage is not subject to a claim by ADHS.

22. On or about January 27, 1998 plaintiff wrote ADHS. The letter afforded ADHS and plaintiff's former counsel 20 days in which to assert a claim against the UIM coverage.

23. ADHS and plaintiff's former counsel intervened in the pending lawsuit.

24. On or about May 12, 1998 the circuit court entered an order with respect to the interests of plaintiff's counsel.

25. On or about May 16, 1998 the circuit court entered an order directing plaintiff's counsel to place the remaining UIM funds in a trust account pending resolution of plaintiff's dispute with ADHS.

26. On or about October 2, 1998 ADHS requested notice of future hearings in the circuit court action.

27. In mid 2002 plaintiff negotiated a settlement with a remaining tortfeasor. Plaintiff executed a release in favor of the tortfeasor.

28. ADHS was not involved in the settlement process and has not executed a release.

29. The total recovery is $550,000.00.

30. The total paid by Medicaid for services related to the accident is $215,645.30.

31. The parties have stipulated that, had plaintiff gone to trial, she would have offered proof that her damages are

$3,040.708.12. ADHS does not intend to offer proof on this question and agrees, for purposes of this dispute, plaintiff's figure is a reasonable estimation.

Respectfully submitted,

ARKANSAS DEPARTMENT
OF HUMAN SERVICES
OFFICE OF CHIEF COUNSEL

/s/ Richard B. Dahlgren
Richard B. Dahlgren
Attorney – Bar #77038
700 Main Street, S260
Little Rock, AR 72201
(502) 682-8934

[Certificate Of Service Omitted In Printing]

IN THE UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF ARKANSAS
WESTERN DIVISION

HEIDI AHLBORN, Plaintiff VS. ARKANSAS DEPARTMENT OF HUMAN SERVICES; DIRECTOR OF THE ARKANSAS DEPARTMENT OF HUMAN SERVICES; AND DIRECTOR OF THE THIRD PARTY LIABILITY UNIT, DIVISION OF MEDICAL SERVICES OF THE ARKANSAS DEPARTMENT OF HUMAN SERVICES Defendants	)	CASE NO. 4-02-CV00607 GTE

MEMORANDUM IN SUPPORT OF DEFENDANTS' MOTION FOR SUMMARY JUDGMENT

(Filed Mar 06, 2003)

* * *

EXHIBIT 3

Department of Health & Human Services — Health Care Financing Administration

Regional Office VI
1200 Main Tower Building
Dallas, Texas 75202

June 1, 1988

DALLAS REGIONAL MEDICAL SERVICES
LETTER NO. 88-23

To: State Agencies Administering Approved Medical Assistance Plans

SUBJECT: State Third Party Liability (TPL) Subrogation Legislation

This is to advise you of a development in TPL subrogation legislation which is occurring in many States and which is in conflict with the Social Security Act. We refer to the passage of State lien laws which permit a Medicaid recipient, who initiates pursuit of TPL recovery from a liable third party, to keep a fixed percentage of the recovered amounts before the State (and Federal Government) receives its share of the settlement. Recently we were informed by counsel that these provisions are in conflict with Section 1912 of the Act.

Section 1902(a)(45) of the Act mandates, as a condition of eligibility, that recipients assign to the State, in accordance with Section 1912, their right to recover from third parties. Section 1912(b) of the Act states that the remainder of any amounts collected under an assignment pursuant to Section 1912(a) shall be paid to the recipient after the State recovers (with appropriate reimbursement to the

Federal Government) what it paid on behalf of the recipient.

In the absence of specific State provisions assuring full reimbursement of the Federal share, the State laws in question would be in conflict with Section 1912(b). As a result, the State's actual recovery becomes impermissibly reduced such that the full Federal share (based on the total net recovery) would not be refunded. The recipient has a right only to the remainder after Medicaid payments are fully reimbursed.

While a State is certainly permitted to give part (or even all) of its recovery to a recipient, Section 1912 does not allow a State to give away the Federal share. Moreover, since Title XIX does not authorize any payments to the recipient until Medicaid is fully repaid, any payment to recipients can be made only after the State has credited its recovery and established the amount of the Federal share to be returned.

Furthermore, the only amounts which can be paid out prior to State recoupment are legitimate administrative expenses. This is based upon an interpretation of "net recovery" in Section 1903(d)(3) of the Act, which speaks about the pro rata share of the recovery to which the United States is equitably entitled. "Net recovery" is interpreted to mean the settlement amount less procurement costs, including attorney fees. The regulation which discusses the basic rule is applicable to Medicare beneficiaries (42 CFR 405.423(b) and (c)), but, by analogy, a similar application to Medicaid recipients can be made.

To The Reader Of "Third Party Liability in The Medicaid Program: A Guide To Successful State Agency Practices"

Notice Of Errata

This is to advise all readers of the Guide that there are three statutory references in State lien laws in the recently updated Guide which are in conflict with Federal law: The provisions in question are cited below. In essence, these provisions state that any recipient who initiates an action to recover damages or compensation from a liable third party shall receive no less than a certain fixed percentage of the total amount recovered after the deduction of attorney fees and costs.

The references are found in section IV of the Guide, entitled Successful State Practices, Part E, Model Legislation. Please note that only those paragraphs cited below are in conflict with the Federal statute, not the entire law, and that the sections should be annotated as being in conflict with Federal law:

Arkansas – Public Welfare Statute #83 – 171.1 C
District of Columbia – Health Care Assistance Reimbursement Act of 1984 – Section 8. Lien (c)
Iowa Code 498 – 75.4(2)

The basis for legal conflict is found in section 1912(b), of the Social Security Act. This section states that the remainder of any amounts collected under an assignment pursuant to section 1912(a) shall be paid to the Medicaid recipient after the State recovers (with appropriate reimbursement to the Federal Government) what it paid on behalf of the recipient. The provisions in question could result in the State's recovering (and returning to the Federal Government) less than the full amount required

under section 1912(b). This conflict has only recently been called to our attention by counsel.

Arkansas has already repealed the referenced citations, and this reference, therefore, should be deleted from the Guide. With regard to the references for the District of Columbia and Iowa, those sections should be stricken as best practices. An annotation as to the conflict with Federal law in the absence of specific State provisions assuring full reimbursement of the Federal share based upon the total recovery, will suffice, with a cross reference to section 1912(b) of the Act.

If the reader has questions with regard to this notice, please contact:

Health Care Financing Administration
Bureau of Quality Control
Attn: Third Party Liability Branch
Room 273, East High Rise Building
6325 Security Boulevard
Baltimore, Maryland, 21207
Tel.: (301) 966-3393

EXHIBIT 21

DEPARTMENT OF HEALTH & HUMAN SERVICES — Health Care Financing Administration

433(D)-1-GEN;SEW

Region VIII
Federal Office Building
1961 Stout Street
Denver CO 80294

Sep 2, 1994

HEALTH CARE FINANCING ADMINISTRATION
REGIONAL IDENTICAL LETTER NO. 94-134

TO: STATE MEDICAID DIRECTORS

SUBJECT: THIRD PARTY LIABILITY RELATIONSHIP TO ISSUE OF LIENS

Federal law at section 1917(a) of the Social Security Act (the Act), and implementing regulations at 42 CFR 433.36 prohibit you from imposing liens against the property of any individual prior to his/her death because of medical assistance paid or to be paid on his/her behalf under the State plan, except in very limited circumstances.

However, section 1902(a)(25)(A) of the Act requires you to ascertain the legal liability of third parties to make payments which Medicaid would otherwise have to make. A third party is defined in the regulations at 42 CFR 433.136 as any individual, entity, or program that is, or may be, liable to pay all or part of the expenditures for medical assistance furnished under the State plan. This includes any monetary judgment or settlement from a tort or casualty liability claim. Where such a legal liability exists, section 1902(a)(25)(B) of the Act requires you to seek reimbursement for medical assistance payments already made.

A Medicaid recipient, at the time of application and as a condition of eligibility for Medicaid, assigns to the State his/her rights to payment from any third party and must cooperate with you in your pursuit of any third party who might be liable for payment, as required by section 1912(a)(1) of the Act. Thus, under this provision in Federal law and the implementing regulations at 42 CFR 433.145, you have claim to the amount recovered by the recipient, even though you may not have been a party to the litigation.

If, under State law, a lien is not being placed upon the Medicaid recipient's property, but rather is being placed upon the tortfeasor's (the defendant in the personal injury litigation) property or upon funds which are set aside to be used in a settlement of the litigation, but which have not become the recipient's property, then there would be no conflict with section 1917(a) of the Act. This is because section 1917(a) only precludes you from placing a lien on an individual's property.

However, under the circumstances described in this letter, you have an interest in the potential personal injury settlement when a recipient's rights to recover payment for medical care must have been assigned to you under section 1912 of the Act in order for him/her to be eligible for Medicaid. In that event, if you place a lien on these funds, it does not violate the Medicaid statute. However, you may not impose a lien on any of the recipient's property which has not been assigned to you.

If you have any questions, please call Sandra White at 303-844-6216, extension 376.

/s/ Gary Wilks
Gary Wilks
Associate Regional
Administrator
Division of Medicaid

EXHIBIT 22

[LOGO] DEPARTMENT OF HEALTH & HUMAN SERVICES — Health Care Financing Adm.

6325 Security Boulevar
Baltimore, MD 21207

JUN 5, 1996

TO : ALL STATE MEDICAID DIRECTORS

SUBJECT : Treating Disability Trusts Under Transfer of Assets, Trust, Estate Recovery, and Third Party Liability Rules – INFORMATION

Transfer and Trust Rules of OBRA '93

The Omnibus Budget Reconciliation Act of 1993 (OBRA '93) generally tightened eligibility rules governing the use of trusts by Medicaid applicants and recipients to discourage the transfer or sheltering of income and resources. Section 1917(c) of the Social Security Act (the Act) prescribes a penalty for individuals who transfer assets for less than fair market value. Section 1917(d) requires that States count, for purposes of an individual's Medicaid eligibility, trusts established by an individual (or certain other designated persons) if assets of the individual were used to form all or part of the trust corpus. An individual's "assets", as defined in section 1917(e)(1)(A), include all income and resources of the individual and of the individual's spouse, including any income or resources which the individual or spouse *is entitled to but does not receive* because of action by the individual or by certain other designated persons or entities.

Recently, several State courts have focused on the right of disabled individuals to receive Medicaid after assets they have received as a third party settlement or award have been placed into a trust. Because of the definition of assets

introduced by OBRA '93, the trust and transfer rules could apply to the proceeds of a disabled individual's settlement with or judgment against a third party, such as a casualty, insurance company. The rules could apply if the individual would have otherwise been legally entitled to these proceeds had they not been diverted away from the individual into a trust.

To be covered by the trust rules in section 1917(d), a trust must have been established by an individual, other than by will, with assets of the individual forming all or part of the trust corpus. The trust is considered to have been "established by the individual" if it has been established by the individual; the spouse; a person, including a court or administrative body with legal authority to act in place of or on behalf of the individual or spouse; or by a person, including any court or administrative body acting at the direction or upon the request of the individual or spouse.

If a court establishes a trust on behalf of or at the behest of an individual, it is covered by the trust rules. If a third party establishes a trust to satisfy a judgment or to pay a settlement and the trust is required by or approved by a court or administrative body, such a trust also falls within the coverage of section 1917(d). The court or administrative body has acted, in its legal capacity, on behalf of or at the request of the individual, to help establish the trust. Even absent the involvement of the court, if the individual has requested a trust, or accepted the terms of a trust to resolve a claim, the trust established by a third party falls within the coverage of section 1917(d) because the third party's actions are interpreted as those of a person acting at the direction of or upon the request of the individual.

As a general rule, then, a trust which results from a third party award or settlement is regarded as subject to the trust rules. This means that the corpus of the trust, interest on the corpus, and payments from the trust will be considered as either available resources, income, or as transferred for less than fair market value, depending upon the rules in section 1917(d) relating to how the trust is constructed and how much it can benefit the individual.

There are, however, several exceptions to the general rules which could apply to disability trusts established by third parties. Section 1917(d)(4)(A) says that the trust rules do not apply to a trust containing the as sets of a disabled individual under age 65. A second exception which could apply to third party settlements is contained in section 1917(d)(4)(C). This exception applies to "pooled" trusts which contain the assets of a disabled individual if the trust is established and managed by a non-profit association. Separate accounts must be maintained for each trust beneficiary, although these accounts may be pooled for purposes of managing and investing the trust funds.

<u>How Third Party Liability (TPL) Rules and Assignment of Rights Affect Trusts</u>

Federal law at section 1902(a)(25)(A) of the Act requires States to take all reasonable measures to ascertain the legal liability of third parties to <u>make</u> payments which Medicaid would otherwise have to make. A third party is defined in the regulations at 42 CFR 433.136 as any individual, entity, or program that is or may be liable to pay all or part of expenditures for medical assistance furnished under the State plan. Where such a legal liability exists, section 1902(a)(25)(B) requires a State to seek

reimbursement for medical assistance payments already made.

All individuals, at the time of application and as a condition of eligibility for Medicaid, must assign to the State their rights to payment for medical care from any third party and, subject to several exceptions, must cooperate with the State in its pursuit of any third party who might be liable for such payment as required by section 1912(a)(1) of the Act and 42 CFR 433.145 of the Medicaid regulations.

Thus, if an individual is already Medicaid eligible at the time he or she receives a third party settlement or judgment, the State has claim to any portion of the proceeds which were intended to pay for medical care for the individual that is covered by Medicaid. If the individual negotiates with the third party to place these amounts in a trust or otherwise fails to help make the amounts available to the State, then that individual has violated the condition of eligibility in section 1912 which requires the individual to cooperate with the State in obtaining payments for medical care from a third party. The individual would lose eligibility, regardless of the trust provisions and exceptions in sections 1917(d)(4)(A) and (C).

If State laws permits, a State can place a lien upon a third party's property, as in a situation involving the property of a tortfeasor or defendant in a personal injury suit, or upon funds which are set aside to be used in a settlement, but which have not yet become the property of the Medicaid applicant or recipient.

Section 1917(a) precludes States from placing liens on individual's property. However, because a potential personal injury settlement is not yet the plaintiff's property,

it can be subject to a TPL lien. Also, proceeds placed in a trust are not the property of the individual, but belong to the trust. As such, a State could place a TPL lien on any proceeds in a trust which could be used to pay for medical care covered in the State's plan, *provided there were State laws allowing this.*

To avoid the lien issue, but protect its rights, a State could come to an agreement with a plaintiff on the settlement of a tort action in order to get an appropriate share. Alternatively, the State could intervene in the case and represent its own interests directly. Since the individual has assigned to the State his or her rights to recover payment for medical care under section 1912, the State has an interest which it can represent directly.

When TPL Does Not Affect a Trust

The situation is different if the individual receives a third party settlement or judgment prior to applying for Medicaid. At the time of application, the third party has extinguished its legal liability to the individual by paying off the judgment or providing settlement proceeds. As a result, the individual will no longer have a right to any third party payments to assign to the State. This would be the case, unless the trust itself has the purpose of providing medical care that would otherwise be covered under Medicaid. In the case of such a trust, the State could pursue the trust as a liable third party. However, many trusts established as the result of a judgment or settlement are designed as "supplemental needs" trusts. These kinds of trusts are drafted so that the trustee can only pay for items or services for the individual which are not covered by Medicaid and/or other similar programs.

How the proceeds of a judgment or settlement will affect a disabled individual depends upon their form. If the individual has received the proceeds outright and retained them, they are likely to be counted as income or resources that are available to the individual for eligibility purposes. These proceeds, if large enough, could render the individual ineligible. If, on the other hand, the proceeds have been placed in a trust, the result depends upon whether the general trust rules apply or whether the trust qualifies for an exception.

Trusts Which Meet the Exceptions in Section 1917(d)(4)

A disabled individual might avoid having the trust counted if the trust is designed to meet one of the exceptions in section 1917(d)(4). To qualify for the exceptions, the trust must be established by an appropriate person or entity, as well as meet other requirements. For purposes of section 1917(d)(4)(A), the trust must be established for a disabled individual under age 65 by a parent, grandparent, legal guardian, or a court (but not by the individual). If the trust is established by the court and meets the other (d)(4)(A) requirements, then it would be subject to this exception. If the third party itself establishes the trust at the direction of or upon the request of any of the enumerated parties (all of whom are considered substitutes for the individual), the trust qualifies for this exception, with the third party acting, in effect, at the direction or upon the request of the individual.

The second exception for a disabled individual in section 1917(d)(4)(C) for a "pooled" trust requires that the trust be established and managed by a non-profit association, with an account for the individual established solely for the

individual's benefit by the individual, a parent or grandparent, legal guardian, or by a court. Again, if the trust account is established by the court, the exception would apply. The exception would also apply if the third party itself establishes the trust account at the direction of or upon the request of any of the enumerated parties.

Treating Excepted Trusts: Use of Funds and Estate Recovery

If the trust meets one of the exceptions, the state can monitor distributions from the trust to be sure that, in the case of a (d)(4)(A) trust, funds in the trust are used for the benefit of the disabled individual, and in the case of a (d)(4)(C) trust account *solely* for the disabled individual's benefit. Once the disabled individual dies, the State must collect whatever remains in the trust or account (if not retained by the "pooled" trust), up to the amount of medical assistance paid by the State.

If the State has not been totally reimbursed from the trust, then the State must follow the estate recovery rules in section 1917(b) of the Act. This provision requires that if an individual has been permanently institutionalized, the State must seek recovery from the individual's estate of any assistance correctly paid or upon sale of a home that has been subject to a lien imposed on account of medical assistance the State has paid.

Section 1917(b) also requires the State to pursue recovery from as individual's estate for the costs of nursing facility services, home and community-based services, and related hospital and prescription drug services, in the case of individuals who received these services when they were age 55 or older. States can also choose to pursue the costs

of any other items or services under the State plan for these same individuals.

If you or your staff have any questions concerning the above, please contact your regional office.

/s/ Sally K. Richardson
Sally K. Richardson
Director
Medicaid Bureau

cc: All Associate Regional Administrators
Division of Medicaid

IN THE UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF ARKANSAS
WESTERN DIVISION

HEIDI AHLBORN, Plaintiff VS. ARKANSAS DEPARTMENT OF HUMAN SERVICES; DIRECTOR OF THE ARKANSAS DEPARTMENT OF HUMAN SERVICES; AND DIRECTOR OF THE THIRD PARTY LIABILITY UNIT, DIVISION OF MEDICAL SERVICES OF THE ARKANSAS DEPARTMENT OF HUMAN SERVICES, Defendants	)	CASE NO. 4-02 CV 00607GTE

PLAINTIFF'S RESPONSE TO DEFENDANT'S STATEMENT OF MATERIAL FACTS

Comes Heidi Ahlborn, Plaintiff herein, and, for her response to Defendants' Statement of Material Facts, pursuant to Federal Rule 56.1, states:

1. Plaintiff does not controvert the accuracy of the factual matters set forth in paragraphs 1 thru 31 of Defendants' Statement of Material Facts as to which there is no genuine issue to be tried.

PLAINTIFF'S STATEMENT OF MATERIAL FACTS

Comes Heidi Ahlborn, Plaintiff herein, and, pursuant to Local Rule 56.1, submits, in connection with her

cross-motion for summary judgment, the following statement of material facts as to which she contends there is no genuine issue to be tried.

1. As a result of the January 2, 1996 motor vehicle accident, Plaintiff sustained severe and permanent personal injuries.

2. As a direct result of the motor vehicle accident on January 2, 1996, Plaintiff has incurred past medical expenses and will, as a direct result of these injuries, incur significant future medical expenses.

3. As a direct result of the injuries sustained in January 2, 1996 motor vehicle accident, Plaintiff has in the past experienced pain, suffering and mental anguish and will sustain mental anguish in the future as a consequence of these injuries.

4. As a direct result of injuries sustained in the January 2, 1996 motor vehicle accident, Plaintiff has a significant and permanent physical and mental injury and impairment.

5. Plaintiff has, as a direct result of injuries sustained in the January 2, 1996 motor vehicle accident, sustained a loss of earnings and working time in the past.

6. Plaintiff has, as a direct result of the injuries sustained in the January 2, 1996 motor vehicle accident, suffered a permanent and significant impairment of earning capacity.

7. As of January 2, 1996, Plaintiff was 19 years of age and had a future statistical life expectancy of 59.02 years.

8. As of January 2, 1996, Plaintiff was a full-time college student pursuing a degree in education with a view to a career in teaching and coaching.

9. As a result of injuries sustained in the January 2, 1996 motor vehicle accident, Plaintiff has been and will be unable to pursue a college-level education due to her permanently impaired level of cognitive and intellectual functioning.

10. The motor vehicle accident in which Plaintiff was injured on January 2, 1996 occurred within the State of Arkansas and Arkansas law would govern the elements of damage for which she would have been entitled to compensation had the claims arising out of that been adjudicated by way of trial.

11. Plaintiff has sustained and will sustain, as a result of the injuries received in the January 2, 1996 motor vehicle accident, the following elements of damage recognized by Arkansas law:

(a) Permanent injury;

(b) Past and future medical expenses;

(c) Past and future pain, suffering and mental anguish;

(d) Past loss of earnings and working time;

(e) Permanent impairment of ability to earn in the future.

12. At the time of the compromise settlement of the claims arising out of Plaintiff's injuries in the January 2, 1996 motor vehicle accident, there was no allocation by agreement or adjudication of the proceeds from such

compromise settlement among the elements of damage arising under Arkansas law.

HEIDI AHLBORN

Plaintiff

BY: H. DAVID BLAIR #65004
Attorney at Law
P. O. Box 2135
Batesville, Arkansas 72503
870-793-8350

-and-

PHILLIP FARRIS #74051
Attorney at Law
P. O. Box 2496
Batesville, Arkansas 72503
870-793-7556

By: /s/ H. David Blair
H. David Blair

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IN THE UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF ARKANSAS
WESTERN DIVISION

HEIDI AHLBORN, Plaintiff VS. ARKANSAS DEPARTMENT OF HUMAN SERVICES; KURT KNICKREHM, DIRECTOR OF THE ARKANSAS DEPARTMENT OF HUMAN SERVICES; WAYNE OLIVE, DIRECTOR OF THE THIRD PARTY LIABILITY UNIT; ROY JEFFUS, INTERIM DIRECTOR, DIVISION OF MEDICAL SERVICES OF THE ARKANSAS DEPARTMENT OF HUMAN SERVICES Defendants	)	CASE NO. 4-02-CV.00607 GTE

DEFENDANTS' RESPONSE TO PLAINTIFF'S STATEMENT OF MATERIAL FACT

(Filed Apr. 23, 2003)

Defendants, for their response to Plaintiff's Statement of Material Fact submitted pursuant to Rule 56.1 state:

1. As a result of the January 2, 1996 motor vehicle accident, plaintiff sustained severe and permanent personal injuries.

Response: Admitted.

2. As a direct result of the motor vehicle accident on January 2, 1996, plaintiff has incurred past medical expenses and will, as a direct result of these injuries, incur significant future medical expenses.

Response: Defendants admit the motor vehicle accident resulted in past medical expenses, the costs of which were borne by defendants. Admits plaintiff will require future treatment.

3. As a direct result of the injuries sustained in January 2, 1996 motor vehicle accident, plaintiff has in the past experienced pain, suffering and mental anguish and will sustain mental anguish in the future as a consequence of these injuries.

Response: Admitted.

4. As a direct result of injuries sustained in the January 2, 1996 motor vehicle accident, plaintiff has a significant and permanent physical and mental injury and impairment.

Response: Admitted.

5. Plaintiff has, as a direct result of injuries sustained in the January 2, 1996 motor vehicle accident, sustained a loss of earnings and working time in the past.

Response: Admitted.

6. Plaintiff has, as a direct result of the injuries sustained in the January 2, 1996 motor vehicle accident, suffered a permanent and significant impairment of earning capacity.

Response: Admitted.

7. As of January 2 1996 plaintiff was 19 years of age and had a future statistical life expectancy of 59.02 years.

Response: Admitted.

8. As of January 2, 1996 plaintiff was a full-time college student pursuing a degree in education with a view to a career in teaching and coaching.

Response: Admitted.

9. As a result of injuries sustained in the January 2, 1996 motor vehicle accident, plaintiff has been and will be unable to pursue a college-level education due to her permanently impaired level of cognitive and intellectual functioning.

Response: Admitted.

10. The motor vehicle accident in which plaintiff was injured on January 2, 1996 occurred within the State of Arkansas and Arkansas law would govern the elements of damage for which she would have been entitled to compensation had the claims arising out of that been adjudicated by way of trial.

Response: Defendants admit the factual allegations of paragraph 10 but deny all statements, assertions or conclusions of law.

11. Plaintiff has sustained and will sustain, as a result of the injuries received in the January 2, 1996 motor vehicle accident, the following elements of damage recognized by Arkansas law:

(a) Permanent injury;

(b) Past and future medical expenses;

(c) Past and future pain, suffering and mental anguish;

(d) Past loss of earnings and working time;

(e) Permanent impairment of ability to earn in the future.

Response: Defendants admit the factual allegations of paragraph 11 but deny all statement, assertions and conclusions of all.

12. At the time of the compromise settlement of the claims arising out of plaintiff's injuries in the January 2, 1996 motor vehicle accident, there was no allocation by agreement or adjudication of the proceeds from such compromise settlement among the elements of damage arising under Arkansas law.

Response: Admitted.

Respectfully submitted,

ARKANSAS DEPARTMENT
OF HUMAN SERVICES
OFFICE OF CHIEF COUNSEL

/s/ Richard B. Dahlgren

Richard B. Dahlgren
Attorney – Bar #77038
700 Main Street – S260
Little Rock, AR 72201
(501) 682-8934

[Certificate Of Service Omitted In Printing]

No. 04-1506

NOV 2 2 2005

In The

Supreme Court of the United States

ARKANSAS DEPARTMENT OF
HEALTH AND HUMAN SERVICES, et al.,

Petitioners,

v.

HEIDI AHLBORN,

Respondent.

**On Writ Of Certiorari To The
United States Court Of Appeals
For The Eighth Circuit**

BRIEF FOR THE PETITIONERS

MIKE BEEBE, Arkansas Attorney General
LORI FRENO, Assistant Attorney General
(*Counsel of Record*)
323 Center Street, Suite 200
Little Rock, AR 72201
(501) 682-1314 Fax: (501) 682-2591

*Attorneys for Petitioners
Arkansas Department of
Health and Human Services, et al.*

COCKLE LAW BRIEF PRINTING CO. (800) 225-6964
OR CALL COLLECT (402) 342-2831

QUESTION PRESENTED

Whether federal Medicaid law, which requires that a medical assistance recipient assign to the state any right to payment from a third party that is liable for the recipient's medical expenses, and which also prohibits the placement of a pre-death lien upon a recipient's "property," entitles the state to full reimbursement from personal injury settlement proceeds of Medicaid benefits paid on the recipient's behalf for medical costs caused by the third party, regardless of what portion of the settlement proceeds are designated as compensation for medical care?

PARTIES TO THE PROCEEDING

The parties to the proceeding are:

HEIDI AHLBORN, an individual;

ARKANSAS DEPARTMENT OF HEALTH AND HUMAN SERVICES;[1] JOHN SELIG, Director of the Arkansas Department of Health and Human Services; GLORIA CHUNN, Chief Program Administrator, Division of Medical Services, Arkansas Department of Health and Human Services; ROY JEFFUS, Director of Division of Medical Services, Arkansas Department of Human Services.

[1] Following the filing of the Petition for Writ of Certiorari, several changes occurred regarding the status of the Petitioners: (1) the agency's name changed to Arkansas Department of Health and Human Services; (2) John Selig succeeded Kurt Knickrehm as Director; (3) Gloria Chunn now performs the duties previously performed by Wayne Olive; and (4) Roy Jeffus is now a permanent, as opposed to interim, director.

TABLE OF CONTENTS

	Page
QUESTION PRESENTED FOR REVIEW	i
PARTIES TO THE PROCEEDING	ii
TABLE OF CONTENTS	iii
TABLE OF AUTHORITIES	v
OPINIONS BELOW	1
JURISDICTION	1
STATUTES AND REGULATIONS INVOLVED	1
STATEMENT	5
A. Factual Background	5
B. Federal Statutory and Regulatory Background	10
1. The Medicaid Program In General	10
2. Third Party Assignment And Recovery Provisions (TPL Provisions)	11
3. The "Anti-Lien Provision"	14
C. Arkansas's Compliance with the Act's TPL Provisions	14
D. Procedural History	16
1. The District Court's Decision	16
2. The Court Of Appeals' Decision	19
SUMMARY OF ARGUMENT	21
ARGUMENT	24

TABLE OF CONTENTS – Continued

Page

I. Medicaid's TPL Provisions Mandate Full Reimbursement To The Medicaid Program From Third Party Personal Injury Settlement Proceeds 24

A. The Plain Language Of The Federal TPL Provisions Reflect Congress's Intent To Create A Broad Right Of Reimbursement For The Medicaid Program 26

B. Arkansas's Third Party Assignment And Recovery Laws, Which Were Enacted In Compliance With The Federal TPL Provisions, Do Not Violate The Federal Anti-Lien Provision 32

II. The Secretary's Adjudications And Interpretations Addressing Medicaid, Which Is A "Complex And Highly Technical Regulatory Program," Are Entitled To Deference And Respectful Consideration 36

A. The Departmental Appeals Board's Rulings That The Medicaid Program Is Entitled To Full Reimbursement Are Entitled To *Chevron* Deference 37

B. The Secretary's Interpretations Addressing The Relationship Between The Federal TPL And Anti-Lien Provisions Are Entitled To Respectful Consideration 41

III. Full Reimbursement Of The Medicaid Program Is Preferable From A Policy Standpoint 45

CONCLUSION 49

TABLE OF AUTHORITIES

Page

FEDERAL CASES

Atkins v. Rivera, 477 U.S. 154 (1986) 10

Blue Chip Stamps v. Manor Drug Stores, 421 U.S. 723 (1975) 26

Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc., 467 U.S. 837 (1984) 22, 36, 41

Christensen v. Harris County, 529 U.S. 576 (2000) 44

Deal v. United States, 508 U.S. 129 (1993) 35

Ernst & Ernst v. Hochfelder, 425 U.S. 185 (1976) 26

FDA v. Brown & Williamson Tobacco Corp., 529 U.S. 120 (2000) 30, 31

Harris v. McRae, 448 U.S. 297 (1980) 10, 11

Schweiker v. Gray Panthers, 453 U.S. 34 (1981) 10, 11, 24, 25

Skidmore v. Swift & Co., 323 U.S. 134 (1944) 36, 44

Sullivan v. Stroop, 496 U.S. 478 (1990) 26

United States v. Mead Corp., 533 U.S. 218 (2001) 36, 37, 44

Wisconsin Dep't of Health and Family Services v. Blumer, 534 U.S. 473 (2002) ..... *passim*

STATE CASES

Calvanese v. Calvanese, 710 N.E.2d 1079 (N.Y. 1999), *cert. denied*, 528 U.S. 928 (1999) 30, 47

Cricchio v. Pennisi, 683 N.E.2d 301 (N.Y. 1997) 30

Houghton v. Department of Health, 57 P.3d 1067 (Utah 2002), *cert. denied*, 538 U.S. 945 (2003) 30

TABLE OF AUTHORITIES – Continued

Page

Martin v. City of Rochester, 642 N.W.2d 1 (Minn. 2002), *cert. denied*, 539 U.S. 957 (2003) 30

Waterall v. Waterall, 155 S.W.3d 30 (Ark. App. 2005) 35

Wilson v. State, 10 P.3d 1061 (Wash. 2000), *cert. denied*, 532 U.S. 1020 (2001) 30

DECISIONS OF THE DEPARTMENT OF APPEALS BOARD, UNITED STATES DEPARTMENT OF HEALTH & HUMAN SERVICES

California Dep't of Health Services, DAB No. 1504, 1995 WL 66334 (Dep't of Health & Human Services January 5, 1995) 38, 46, 47, 49

Washington State Dep't of Social & Health Services, DAB No. 1561, 1996 WL 157123 (Dep't of Health & Human Services February 7, 1996) 13, 40

FEDERAL STATUTES

28 U.S.C. § 1254(1) 1

42 U.S.C. § 1302 ..... 5, 37

42 U.S.C. §§ 1396-1396v 2

42 U.S.C. § 1396 ..... 5, 10, 11

42 U.S.C. § 1396a ..... *passim*

42 U.S.C. § 1396k ..... *passim*

42 U.S.C. § 1396p 4, 8, 14, 28, 40

TABLE OF AUTHORITIES – Continued

Page

FEDERAL REGULATIONS

42 C.F.R. § 430.0 4

42 C.F.R. § 430.10 ..... 5, 11

42 C.F.R. § 430.35 ..... 4, 11

42 C.F.R. § 433.36. ..... 5, 28

42 C.F.R. § 433.136 12

42 C.F.R. § 433.140 ..... 4, 11

45 C.F.R. § 16.4 ..... 5, 38

STATE STATUTES

Ark. Code Ann. § 20-76-201 14

Ark. Code Ann. § 20-77-301 *et seq.* 14

Ark. Code Ann. § 20-77-301 ..... 15, 16, 33

Ark. Code Ann. § 20-77-302 ..... 15, 33

Ark. Code Ann. § 20-77-303 15

Ark. Code Ann. § 20-77-307 ..... 6, 9, 15, 31, 34

OTHER AUTHORITIES

HCFA letter entitled "Treating Disability Trusts Under Transfer Of Assets, Trust, Estate Recovery, And Third Party Liability Rules – INFORMATION (issued June 6, 1996) 43

HCFA letter entitled "Third Party Liability Relationship to Liens" (issued September 2, 1994) 42

TABLE OF AUTHORITIES – Continued

Page

HCFA letter entitled "State Third Party Liability (TPL) Subrogation Legislation" (issued June 1, 1988) 41

S. Rep. No. 99-146 at 279 (1985), *reprinted in* 1986 U.S.C.C.A.N. 42, 312 ..... 24, 29

OPINIONS BELOW

The court of appeals' opinion (Pet. App. 1-15) is reported at 397 F.3d 620 (8th Cir. 2005). The district court's opinion (Pet. App. 16-31) is reported at 280 F.Supp.2d 881 (E.D. Ark. 2003).

JURISDICTION

The judgment of the court of appeals was entered on February 9, 2005 (Pet. App. 1-15). The petition for a writ of certiorari was filed on May 11, 2005, and was granted on September 27, 2005. This Court has jurisdiction under 28 U.S.C. § 1254(1).

STATUTES AND REGULATIONS INVOLVED

42 U.S.C. § 1396a

(a) Contents. A State plan for medical assistance must –

. . .

(25) provide –

(A) that the State or local agency administering such plan will take all reasonable measures to ascertain the legal liability of third parties (including health insurers, group health plans (as defined in section 1167(1) of Title 29), service benefit plans, and health maintenance organizations) to pay for care and services under the plan.

. . .

(B) that in any case where such a legal liability is found to exist after medical assistance has been made available on behalf of the individual and where the amount of reimbursement the State can reasonably expect to recover exceeds the costs of such recovery, the State or local agency will seek reimbursement for such assistance to the extent of such legal liability;

. . .

(H) that to the extent that payment has been made under the State plan for medical assistance in any case where a third party has a legal liability to make payment for such assistance, the State has in effect laws under which, to the extent that payment has been made under the State plan for medical assistance for health care items or services furnished to an individual, the State is considered to have acquired the rights of such individual to payment by any other party for such health care items or services;

42 U.S.C. § 1396k

(a) For the purpose of assisting in the collection of medical support payments and other payments for medical care owed to recipients of medical assistance under the State plan approved under this subchapter [42 U.S.C. §§ 1396-1396v], a State plan for medical assistance shall –

(1) provide that, as a condition of eligibility for medical assistance under the State plan to

an individual who has the legal capacity to execute an assignment for himself, the individual is required –

(A) to assign the State any rights, of the individual or of any other person who is eligible for medical assistance under this subchapter and on whose behalf the individual has the legal authority to execute an assignment of such rights, to support (specified as support for the purpose of medical care by a court or administrative order) and to payment for medical care from any third party.

. . .

(C) to cooperate with the State in identifying, and providing information to assist the State in pursuing, any third party who may be liable to pay for care and services available under the plan

. . .

(b) Such part of any amount collected by the State under an assignment made under the provisions of this section shall be retained by the State as is necessary to reimburse it for medical assistance payments made on behalf of an individual with respect to whom such assignment was executed (with appropriate reimbursement of the Federal Government to the extent of its participation in the financing of such medical assistance), and the remainder of such amount collected shall be paid to such individual.

42 U.S.C. § 1396p

(a) **Imposition of lien against property of an individual on account of medical assistance rendered to him under a State plan.**

(1) No lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan.

Arkansas Code Annotated § 20-77-307

(a) As a condition of eligibility, every Medicaid applicant shall automatically assign his or her right to any settlement, judgment, or award which may be obtained against any third party to the Department of Human Services to the full extent of any amount which may be paid by Medicaid for the benefits of the applicant.

(b) The application for Medicaid benefits shall, in itself, constitute an assignment by operation of law.

(c) The assignment shall be considered a statutory lien on any settlement, judgment, or award received by the recipient from a third party.

The following statutes and regulations are reproduced in the appendix to the petition for a writ of certiorari:

42 U.S.C. § 1382b(a), Pet. App. 32-36.

42 C.F.R. § 430.0, Pet. App. 36.

42 C.F.R. § 430.35, Pet. App. 36-37.

42 C.F.R. § 433.140(a)(1), Pet. App. 37.

42 C.F.R. § 447.302, Pet. App. 37.

Ark. Code Ann. § 20-76-201(1), Pet. App. 37.

Ark. Code Ann. §§ 20-77-301 through 20-77-307, Pet. App. 38-43.

The following are reproduced in the appendix to the Brief for the Petitioners:

42 U.S.C. § 1396 (2000), 1a

42 U.S.C. § 1302(a) (2000), 1a

42 C.F.R. § 430.10 (2005), 1a

42 C.F.R. § 433.36(a)-(b) (2005), 2a

45 C.F.R. § 16.4 (2005), 3a

STATEMENT

A. Factual Background

Heidi Ahlborn was involved in a motor vehicle accident in January of 1996. J.A. 4, 22, 42. As a result, she suffered severe injuries that required extensive medical care. *Id.* During her medical treatment, Ahlborn received medical benefits under the Arkansas Medicaid program, which is administered by the Arkansas Department of Health and Human Services ("Department"). *Id.* Ahlborn accrued bills for accident-related medical services of approximately $320,000.00, which costs were billed to the Department. J.A. 22, 42. The Arkansas Medicaid program paid Ahlborn's health care providers approximately $215,645.30 for accident-related medical costs, which fully extinguished Ahlborn's financial obligation. J.A. 22, 24, 42.

As a condition of her eligibility for Medicaid benefits, Arkansas law required that Ahlborn assign to the Department her "right to any settlement, judgment, or award" that she might receive from third parties liable for the medical costs resulting from the accident "to the full extent of any amount which may be paid by Medicaid." J.A. 6, 7 (*citing* Ark. Code Ann. § 20-77-307). The State had enacted this assignment provision in compliance with a mandate under federal Medicaid law that requires participating states to have such an assignment in effect. J.A. 14, Pet. App. 8.

The Department sent Ahlborn a questionnaire seeking information about the accident, her insurance status, and whether she had retained an attorney. Mem. In Supp. Of Defs.' Mot. For Summ. J., Ex. 4 and Olive Aff. at ¶ 7. Ahlborn responded, identifying her attorney as John Casteel. *Id.* The Department then sent Casteel two letters in which it notified him of the State Medicaid program's right to reimbursement from any settlement, judgment, or award obtained against any third party liable for Ahlborn's injuries "to the extent of any amount which may be paid by Medicaid for the benefit of the applicant." Mem. In Supp. Of Defs.' Mot. For Summ. J., Exs. 5, 6 and Olive Aff. at ¶ 10. The letters also notified Casteel that no judgment, award, or settlement may be satisfied "without first giving the [D]epartment notice and a reasonable opportunity to establish its interest." *Id.*

Subsequently, on April 11, 1997, Ahlborn filed a personal injury lawsuit in state circuit court without notifying the Department. J.A. 23, 42. In July of 1997, Ahlborn notified the Department that she had received a $25,000.00 policy limit recovery from one tortfeasor. J.A. 23, 42. On three occasions, Ahlborn requested that the

Department waive its Medicaid claim with regard to this recovery, which the Department refused to do. *Id.*

In December of 1997, Ahlborn notified the Department that she had received a $25,000.00 recovery from her uninsured motorists ("UIM") policy, asserting that the recovery was not subject to the Medicaid claim. *Id.*[2] When the Department disagreed, Ahlborn notified it on January 27, 1998, that it had 20 days to assert a claim against the UIM recovery. J.A. 24, 42. The Department (and Casteel) then intervened in the pending lawsuit. *Id.* In May of 1998, the circuit court entered an order directing Ahlborn to hold the UIM recovery in trust pending resolution of her dispute with the Department and Casteel. J.A. 24, 42; Mem. In Supp. Of Defs.' Mot. For Summ. J., Ex. 18.

Ahlborn estimated that her damages from the accident totaled approximately $3,040,708.12, which included medical care, loss of earnings and work time, pain and suffering, and permanent impairment of ability to earn in the future. J.A. 6, 18. Despite inquiries from the Department and its intervention into the lawsuit, Ahlborn reached a compromise settlement with a remaining tortfeasor without notifying the Department of the ongoing negotiations or involving it in the settlement, thus making her total recovery $550,000.00. J.A. 22-23, 24, 42.[3]

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[2] By this stage in the litigation, Ahlborn had retained her present attorneys, H. David Blair and Phillip Farris, in place of John Casteel. J.A. 23; Mem. In Supp. Of Defs.' Mot. For Summ. J., Exs. 8, 10.

[3] This total settlement consisted of: (a) $25,000.00 from Ahlborn's UIM coverage; (b) $25,000.00 recovery representing the policy limit of one tortfeasor; and (c) $500,000.00 from a second tortfeasor. J.A. 16, 18, 42. There was no allocation of the settlement proceeds among the various damages that Ahlborn alleged in her complaint. J.A. 44-45, 49.

The Department asserted a "claim or lien" in the amount of $219,156.78 against the settlement proceeds – which amount was later reduced to $215,645.30 – to reimburse the Arkansas Medicaid program for medical costs paid to or on behalf of Ahlborn as a result of her involvement in the auto accident. J.A. 5, 11, 18.[4]

Ahlborn subsequently brought suit against the Department and several of its officials in the United States District Court for the Eastern District of Arkansas seeking a declaratory judgment. J.A. 3-9. In her lawsuit, Ahlborn argued that the Arkansas Medicaid program was not entitled to full reimbursement from the settlement proceeds for the amount of medical costs that it had paid on her behalf for injuries resulting from the accident. J.A. 5-7. Specifically, she contended that the Medicaid program was not entitled to reimbursement "to the extent it seeks to reach that portion of [her] settlement other than that attributable to medical expenses furnished by Defendant Department." J.A. 7.

Ahlborn based this argument on a provision of federal Medicaid law that is often called the "anti-lien provision," which prohibits the imposition of a lien "against the property of any individual prior to [her] death on account of medical assistance paid or to be paid on [her] behalf" by a State Medicaid program. J.A. 5-6 (*citing* 42 U.S.C. § 1396p). Ahlborn contended that any portion of the settlement proceeds representing compensation for damages other than medical care (e.g., pain and suffering, lost

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[4] As the district court recognized, the slight discrepancies in these amounts reflect adjustments made to exclude Medicaid payments made on Ahlborn's behalf for medical care unrelated to injuries that she sustained in the auto accident. (Pet. App. 18, n.2).

income, etc.) was her "property," and that the federal anti-lien provision thus preempted Arkansas law to the extent that it authorized medical cost reimbursement from any portion of the settlement proceeds that are not "attributable to medical expenses." J.A. 5-7, 17-18.

In response, the Department contended that the amount of settlement proceeds necessary to fully reimburse the Arkansas Medicaid program for medical costs that it paid on behalf of Ahlborn as a result of her accident was not Ahlborn's "property" because she had assigned her interest in those funds to the Department. J.A. 12-13. The Department reasoned that Arkansas's assignment and recovery laws, which provide in part that as a condition of Medicaid eligibility an applicant "shall automatically assign his or her right to any settlement, judgment, or award which may be obtained against any third party to the Department . . . to the full extent of any amount which may be paid by Medicaid for the benefit of the applicant," were enacted in compliance with 42 U.S.C. § 1396a(a)(25), which mandates that Medicaid-participating states (such as Arkansas) effectuate laws under which the State is considered to have acquired a recipient's right to payment by any liable party "to the extent that payment has been made under the State plan for medical assistance." J.A. 12-13, 17-18, Pet. App. 42 (Ark. Code Ann. § 20-77-307(a)).

Because Ahlborn and the third parties with whom she settled did not allocate the settlement proceeds among her various claims, the Department and Ahlborn stipulated to an allocation in order to enable the federal court to rule on the statutory construction issue as a matter of law. J.A. 18-19, 44-45, 49. The parties clarified, however, that the stipulation "in no way affect[ed] the relative position of the

parties as regards the statutory construction issue." J.A. 19.

Adopting the Department's reasoning, the district court held that the federal anti-lien provision did not prevent full reimbursement of the State Medicaid program from the settlement proceeds. Pet. App. 29, 30. The court of appeals overturned this ruling, finding that settlement monies representing compensation for elements other than medical care were Ahlborn's "property" protected by the anti-lien provision. Pet. App. 14.

B. Federal Statutory And Regulatory Background

1. The Medicaid Program In General

Enacted in 1965 as Title XIX of the Social Security Act ("Act"), Medicaid is a publicly funded program designed to pay medical costs for individuals whose income and resources are insufficient to meet the cost of medical care and services that they need. *Atkins v. Rivera*, 477 U.S. 154, 156 (1986) (citations omitted); 42 U.S.C. § 1396 (2000). The primary purpose of the Medicaid program is to provide federal financial assistance to states that elect to reimburse certain costs of medical treatment for needy individuals. *Harris v. McRae*, 448 U.S. 297, 301 (1980). Congress intended Medicaid to be "the payer of last resort, that is, other available resources must be used before Medicaid pays for the care of an individual enrolled in the Medicaid program." S. Rep. No. 99-146 at 279 (1985), *reprinted in* 1986 U.S.C.C.A.N. 42, 312, Pet. App. 44. The common sense policy underlying this intent is evident, considering that "[t]here are limited resources to spend on welfare." *Schweiker v. Gray Panthers*, 453 U.S. 34, 48 (1981).

Although participation in the Medicaid program is entirely optional, once a State such as Arkansas chooses to participate it must comply with the requirements of the Act itself, as well as with those imposed by the United States Secretary of Health and Human Services. ("Secretary"). *Harris*, 448 U.S. at 301; *Schweiker*, 453 U.S. at 37-38. The Centers for Medicare and Medicaid Services ("CMS"),[5] which is a branch of the federal Department of Health and Human Services, administers the Medicaid program federally. *See Wisconsin Dept. of Health & Family Servs. v. Blumer*, 534 U.S. 472, 478 n.1 (2002). Each participating state must develop a "State plan" that comprehensively describes the nature and scope of its Medicaid program, and that provides assurances that the program will be administered in conformity with the Act, regulations promulgated thereunder by the Secretary, and other "applicable official issuances" of the federal Department of Health and Human Services. 42 C.F.R. § 430.10 (2005); *see generally* 42 U.S.C. §§ 1396, 1396a (2000). The federal government may penalize a state's non-compliance by a reduction in or the complete withholding of federal funding to the state. 42 C.F.R. §§ 430.35(a)(1) (2005); *see also* 42 C.F.R. § 433.140(a)(1) (2005) (applies specifically to state's failure to seek reimbursement from liable third party).

2. Third Party Assignment and Recovery Provisions ("TPL" Provisions)

The Act does not authorize the federal government to recover Medicaid expenditures directly from third parties.

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[5] CMS was previously known as the Health Care Financing Administration, or "HCFA."

Instead, it protects the federal fisc by explicitly requiring participating states to pursue reimbursement of state and federal medical assistance payments when third parties[6] are responsible for the injuries underlying those expenses. Once a state receives this reimbursement, the Act requires that it return to CMS the federal portion of the payments.

Specifically, federal law requires that states take "all reasonable measures to ascertain the legal liability of third parties . . . to pay for care and services under the plan." 42 U.S.C. § 1396a(a)(25)(A) (2000). "In cases where such a legal liability is found to exist after medical assistance has been made available on behalf of the [recipient]," the state must "seek reimbursement for such assistance *to the extent of such liability*." 42 U.S.C. § 1396a(a)(25)(B) (2000) (emphasis added). The Act mandates that states enact laws in furtherance of this goal; specifically,

> In any case where a third party has a legal liability to make payment for [medical] assistance, the State has in effect laws under which, *to the extent that payment has been made under the State plan for medical assistance for health care items or services furnished to an individual*, the State is considered to have acquired the rights of such individual to payment by any other party for such health care items or services.

42 U.S.C. § 1396a(a)(25)(H) (2000) (emphasis added). Likewise, the Act mandates that each state require Medicaid applicants, as a condition of eligibility, to assign to the state their right to payment for medical care from any

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[6] 42 C.F.R. § 433.136 defines a "third party" as "any individual, entity or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished under a State plan."

liable third party. 42 U.S.C. § 1396k(a)(1)(A) (2000). A Medicaid recipient also has a duty to "cooperate" with the State "in identifying, and providing information to assist the state in pursuing, any third party who may be liable to pay for care and services available under the plan." 42 U.S.C. § 1396k(a)(1)(C) (2000).

The Act's TPL provisions expressly require the State Medicaid program be reimbursed from third party recoveries before the recipient may receive any remaining amount.[7] Specifically, 42 U.S.C. § 1396k(b) requires:

> [s]uch part of any amount collected by the State under an assignment . . . shall be retained by the State *as is necessary to reimburse it for medical assistance payments made on behalf of an individual* with respect to whom such assignment was executed (with appropriate reimbursement of the Federal Government to the extent of its participation in the financing of such medical assistance), and the remainder of such amount collected shall be paid to such individual.

42 U.S.C. § 1396k(b) (2000) (emphasis added).

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[7] Reasonable litigation expenses and attorney fees are payable from a recovery, however, prior to reimbursement of the Medicaid program if the recipient brings an action against a potentially liable third party. *See* Ark. Code Ann. § 20-77-302 (after payment of reasonable expenses and attorney's fees, the Department shall "receive an amount sufficient to reimburse the [D]epartment the full amount of benefits paid on behalf of the recipient under the medical assistance program"); *Washington State Dep't of Social & Health Services*, DAB No. 1561, 1996 WL 157123 (Dep't of Health & Human Services February 7, 1996), Pet. App. 45, 64-67 (finding appropriate a state law authorizing recovery of attorney's fees and costs "prior to reimbursement of the Medicaid program").

3. The "Anti-Lien Provision"

A separate provision of the Act, which is commonly referred to as the "anti-lien provision," protects a Medicaid recipient's "property" during her lifetime from liens related to medical expenditures made under the Medicaid program. 42 U.S.C. § 1396p(a)(1) (2000). In relevant part, this provision provides that "[n]o lien may be imposed against the property of any individual prior to [her] death on account of medical assistance paid or to be paid on [her] behalf under the State plan." *Id.* The parties in the present case agree that the Act's TPL provisions allow the State Medicaid program to recover some portion of the accident-related medical costs that it paid on Ahlborn's behalf, even in view of the anti-lien provision. They disagree as to the reach of the recovery and assignment provisions, however, and thus to what extent the State Medicaid program may seek reimbursement from the compromise settlement proceeds without running afoul of the anti-lien provision.

C. Arkansas's Compliance With The Act's TPL Provisions

Arkansas participates in the federal Medicaid program and has designated the Arkansas Department of Health and Human Services as the State agency responsible for administrating the State plan. *See* Ark. Code Ann. § 20-76-201(1) (2001). In compliance with the Act, Arkansas enacted laws under which the Department acquires the right of a Medicaid recipient to receive payments from liable third parties who caused the recipient's need for medical care expenditures. *See generally* Ark. Code Ann. § 20-77-301 through 20-77-307 (2001) (providing assignment and recovery mechanism).

As required by the federal TPL provisions, Arkansas law mandates that Medicaid recipients, as a condition of eligibility for benefits, assign to the Department their right to certain payments from liable third parties. Arkansas's assignment and recovery provisions provide in part:

> (a) As a condition of eligibility, every Medicaid applicant shall automatically assign his or her right to any settlement, judgment, or award which may be obtained against any third party to the [State] Department of Human Services to the full extent of any amount which may be paid by Medicaid for the benefit of the applicant.
>
> (b) The application for Medicaid benefits shall, in itself, constitute an assignment by operation of law.
>
> (c) The assignment shall be considered a statutory lien on any settlement, judgment, or award received by the recipient from a third party.

Ark. Code Ann. § 20-77-307(a)-(c) (2001). The law provides for three means through which recovery from a liable third party for medical assistance costs paid to the recipient can be realized: (1) the recipient may bring an action alone and reimburse the State program, (2) the Department may bring an action on its own, or (3) the recipient and Department may prosecute an action together. Ark. Code Ann. §§ 20-77-301, 302, 303 (2001). In no event, however, may an action by the Department operate as a bar "to any action upon the claim or cause of action of the recipient," nor shall it deny to the recipient recovery for damages beyond the medical assistance benefits provided by the

State Medicaid program. Ark. Code Ann. § 20-77-301(b) (2001).

D. Procedural History

1. The District Court's Decision

The Department and Ahlborn filed cross motions for summary judgment in the United States District Court for the Eastern District of Arkansas. Pet. App. 16. The parties agreed that the issue in the case – the extent to which the State could recover Medicaid benefits that it had paid on Ahlborn's behalf from a personal injury lawsuit settlement – was an issue of statutory construction for the Court. *Id.* In a Judgment entered August 22, 2003, the district court granted summary judgment in favor of the Department, holding that "the Medicaid statute is intended to vest States with the right to recover the full payment of medical expenses by a third party liable for causing the injuries which triggered the need for medical care." Pet. App. 30.

As an initial matter, the district court recognized that federal Medicaid statutes were enacted as part of a publicly funded program to provide medical care to individuals lacking the resources to obtain essential medical services, and that the Medicaid program was intended to be the "payer of last resort." Pet. App. 19. It likewise noted that the State of Arkansas, which subjected itself to compliance with the mandates of the Act and regulations promulgated thereunder by voluntarily electing to participate in this program, enacted its assignment and recovery statute in compliance with the federal mandate set forth in 42 U.S.C. § 1396k. Pet. App. 20-21. The court then rejected Ahlborn's argument that the Act's anti-lien provision limited the

Department's right to full reimbursement from the settlement proceeds.

First, the court reasoned that personal injury settlement proceeds that a Medicaid applicant assigns to the Department as a condition of eligibility for Medicaid benefits is not the "property" of the Medicaid beneficiary within the meaning of the anti-lien provision. Pet. App. 22, 23, 30. Adopting the reasoning of the highest courts of Utah and Washington, as well as the dissenting opinion joined by three of the seven justices of the highest court in Minnesota, the district court found that "the anti-lien provision drops out of the analysis" following an assignment because a Medicaid recipient "no longer has an interest in the property (his or her action against third parties) to the extent of the state's expenditures." Pet. App. 26 (citations omitted).

Next, the district court recognized that the United States Department of Health and Human Services, the federal agency charged with administering the Medicaid laws in question, had consistently interpreted the Act in the same manner as the State of Arkansas. Pet. App. 27. Specifically, the court noted that the Secretary, which "has not hesitated to enforce its position against participating States," has taken the position that "States must require, as a condition of eligibility, that recipients assign to the State their right to recover from third parties and that, from any such recovery, the State must recover the full amount of benefits paid on the behalf of the recipient." *Id.* (citations omitted). In finding the Secretary's position entitled to "due consideration," the district court cited to cases in which this Court has recognized the Secretary's "significant expertise" in the context of this "complex and highly technical regulatory program," and has granted the

Secretary "exceptionally broad authority" under the Medicaid statute. Pet. App. 28 (citations omitted).

Finally, the district court recognized that if Ahlborn's lawsuit had been litigated to conclusion or reduced to a sum certain at the time that she had applied for Medicaid benefits, she would have been forced to expend those monies, or "resources," before she would have qualified for Medicaid benefits. *Id.* The district court thus concluded that a Medicaid applicant's unliquidated tort claim is both a "resource" and "property" for purposes of the Medicaid Act, and consequently, "there is nothing incongruent about requiring an applicant, as a condition of Medicaid eligibility, to assign to the State his entire 'rights to payment from third parties.'" Pet. App. 29.

Summarizing its reasoning in support of the Department's interpretation of the Act, the district court explained:

> Section 1396a(a)(25), which [Ahlborn] construes as limiting Arkansas' right of assignment, is harmonized with the remainder of the Medicaid statute by a broader reading. The Medicaid statute requires States to ascertain the "legal liability" of third parties "to pay for care and services" rendered under the Medicaid program, 42 U.S.C. § 1396a(a)(25)(A), and, to pursue recovery to the full "*extent of such legal liability*," 42 U.S.C. § 1396a(a)(25)(B) [district court's emphasis]. Full effect to the statute as a whole is supported by an interpretation of the statutory provisions that does not limit States to the compromise value assigned to the medical expenses component of the assigned claim during settlement negotiations . . . [a]lthough the statutory language in question is far from a model of clarity, when the Court

> considers the statute as a whole, the Secretary's position on the issue, and the legislative history of the Medicaid statute . . . it concludes that the [Department] ha[s] the better argument. The Medicaid statute is intended to vest States with the right to recover the full payment of medical expenses by a third party liable for causing the injuries which triggered the need for medical care.

Pet. App. 29-30.

2. The Court Of Appeals' Decision

A panel of the United States Court of Appeals for the Eighth Circuit reversed, finding that "Ahlborn ha[d] the better of the argument." Pet. App. 2. Like the district court, the court of appeals recognized that Congress intended Medicaid to be a "payer of last resort," and that the "primary purpose of the [Medicaid] program is to provide federal financial assistance to States that elect to reimburse certain costs of medical treatment for needy individuals." Pet. App. 4 (citations omitted). Contrary to the district court, however, the court of appeals found that Ahlborn's unliquidated tort claim remained her "property," and that the federal anti-lien provision thus preempted Arkansas's assignment and recovery provisions "to the extent that they require Ahlborn to assign her rights to recover third-party liability payments for matters other than the cost of her medical care and services." Pet. App. 14.

In so ruling, the court of appeals found that the Arkansas law "requires recoupment from, and places a lien on, the entirety of third-party payments – not just that portion of the third-party payment for medical care."

Pet. App. 5. The court rejected the Department's argument that State law did not conflict with the federal anti-lien provision because the federal TPL provisions *mandate* that Medicaid participating states impose such a reimbursement mechanism. Pet. App. 5-6. Turning to 42 U.S.C. § 1396a(25)(H) and 42 U.S.C. § 1396k(a)(1), the court reasoned that the Act mandates only that participating states recover payments made by third parties "to compensate for medical care." Pet. App. 10. The court explained:

> [w]e believe a straightforward interpretation of the text of these statutes demonstrates that the federal statutory scheme requires only that the State recover payments from third parties to the extent of their legal liability to compensate the beneficiary *for medical care and services* incurred by the beneficiary. Under § 1396a(a)(25)(H), a state Medicaid plan must include provisions specifying that, when the State provides medical benefits to an applicant, "the State is considered to have acquired the rights of such individual to *payment by any other party for such health care items or services.*" [court's emphasis]. The acquisition of rights occurs only in cases where a "third party has a legal liability to make payment for [medical] assistance." *Id.* Section 1396k(a)(1)(A) similarly requires that an applicant assign to the State her right "to *payment for medical care* from any third party." [court's emphasis]. Both statutes are thus limited to rights to third-party payments made to compensate for medical care.

Pet. App. 9-10. The court likewise refused to defer to the Secretary's interpretation of the federal third-party liability provisions, finding deference unwarranted because the

Secretary's interpretation was "inconsistent with the plain language of the [Act]." Pet. App. 11.

Finally, the court found that Ahlborn's unliquidated cause of action was not a "resource" that should have been considered in determining her Medicaid eligibility. Pet. App. 7 & n.1. Finding that Ahlborn lacked the power to convert her cause of action to cash when she applied for Medicaid benefits, it concluded that "although the same cause of action was property; . . . it was not a resource." Pet. App. 7 & n.1, 8 (citation and internal quotations omitted).

SUMMARY OF ARGUMENT

I. The plain language of the federal TPL provisions reflect Congress's unambiguously expressed intent that Medicaid be a "payer of last resort." In summary, they mandate that Medicaid-participating states seek Medicaid reimbursement from legally liable third parties "to the extent of such legal liability," enact laws under which they acquire the rights of the Medicaid recipient to payment by liable third parties "to the extent that payment has been made under the State [Medicaid] plan," and require Medicaid applicants "as a condition of eligibility" to assign to the State any rights to "payment for medical care from liable third parties." The federal TPL provisions establish a priority in favor of full Medicaid reimbursement, mandating that states retain any amount collected pursuant to the pre-eligibility assignment "as is necessary to reimburse it for medical assistance payments made on behalf of the recipient," before any remaining amount be paid to the recipient. Through these provisions, Congress effectively shifted a recipient's medical care costs from the State

Medicaid programs and taxpaying public to the third parties who triggered those costs.

In compliance with these federal mandates, Arkansas enacted laws requiring Medicaid applicants to assign to the Department as a condition of eligibility "his or her right to any settlement, judgment, or award" obtained against a third party "to the full extent of any amount which may be paid by Medicaid for the benefit of the applicant." State law also provides that the assignment shall be considered a statutory lien on any settlement, judgment, or award received from the third party. Because the scope of the assignment under Arkansas law does not exceed the scope mandated by federal law, the court of appeals erred in holding that State law was "preempted" by the federal anti-lien provision. Furthermore, because any property that Ahlborn assigned as a condition of Medicaid eligibility was no longer her "property," Arkansas law did not violate the federal anti-lien provision by placing a statutory lien on any recovery that fell within the scope of the federally-mandated assignment.

II. Any arguable ambiguity as to the breadth of the federal TPL provisions and their relationship to the federal anti-lien provision has been resolved by the United States Secretary of Health and Human Services, to whom this Court recognized Congress delegated "extremely broad regulatory authority . . . in the Medicaid area." Adjudications by Health and Human Services's Departmental Appeals Board, which are entitled to *Chevron* deference, twice confirmed the broad reach of the federal TPL provisions, rejecting state schemes that allowed recipients to keep some portion of third party settlement recoveries prior to full Medicaid reimbursement.

In well-reasoned letters to the states, the Secretary (through HCFA/CMS) has confirmed that the anti-lien provision does not prohibit states from placing liens on third party settlement proceeds. Although these more informal interpretations are not entitled to the same degree of deference as agency adjudications, this Court has long recognized that informal policy interpretations by an agency charged with the administration of a statute are entitled to some level of deference as long as they are informed, reasonable, and persuasive.

III. Sound policy likewise favors full Medicaid reimbursement from settlement proceeds. First, had Ahlborn not applied for Medicaid benefits but rather had she been billed directly by health care providers, she would have been responsible to pay all of her medical bills from the third party settlement proceeds. In enacting the TPL statutes, Congress certainly did not intend to place Medicaid in a less favorable position than a for-profit provider.

Second, it is incongruous to argue on one hand that Ahlborn's resources were so limited at the time of her accident that she qualified for publicly funded medical benefits for the "needy," but on the other hand that she retained a property interest – insulated from the federal TPL reimbursement mandate – in those portions of a personal injury settlement that she and a third party designate as or consider to be something other than recovery for medical care.

Third, Ahlborn's position would force states to intervene into all ongoing litigation or to file independent causes of action against all third party tortfeasors in order to recover Medicaid program expenditures, which would

result in a substantial increase in expenditures of state resources. Requiring states to pursue third parties directly to recover publicly funded medical costs, instead of using lien or subrogation statutes to do so, would force states to spend much more money to recover the same amount of funds, thereby leaving less money to return to the Medicaid program for use by Medicaid applicants in need.

Finally, Ahlborn's approach would promote manipulation in the apportionment of settlement recoveries by the recipient and tortfeasor, in whose interest it would be to lessen the amount of any settlement allocated to medical costs and thereby to reduce the amount owed to Medicaid notwithstanding the amount actually paid out by Medicaid for the patient's care.

ARGUMENT

I. Medicaid's TPL Provisions Mandate Full Reimbursement To The Medicaid Program From Third Party Personal Injury Settlement Proceeds

Congress intended that Medicaid be "the payer of last resort, that is, other available resources must be used before Medicaid pays for the care of an individual enrolled in the Medicaid program." S. Rep. No. 99-146 at 279 (1985), *reprinted in* 1986 U.S.C.C.A.N. 42, 312; Pet. App. 44. Sound fiscal and societal considerations support this intent, such as ensuring that sufficient funds remain in the program for future Medicaid recipients and lessening the burden on state and federal taxpayers. As this Court recognized in *Schweiker v. Gray Panthers*, "[t]here are

limited resources to spend on welfare." 453 U.S. 34, 48 (1981).

Congress advanced this objective through Medicaid's TPL provisions, which require participating states to enact legislation under which the State Medicaid program acquires the rights of recipients to payment for medical costs when a third party caused and is legally liable for those expenses "to the extent that payment has been made under the State plan for medical assistance." 42 U.S.C. § 1396a(a)(25)(H). Through these statutes, Congress effectively shifted a recipient's medical care costs from the Medicaid program and taxpaying public to third parties who caused the recipient's injuries, thereby conserving program funds for other people who do not have sufficient income and resources to pay for needed medical care.

In the present case, the parties agree that the federal recovery and assignment statutes, as well as Arkansas law enacted in compliance with them, permit the State Medicaid program to recover some portion of Ahlborn's settlement proceeds. Their disagreement lies in whether the federal anti-lien provision limits program reimbursement to that portion of the settlement proceeds that the recipient and liable third party designate as recovery for "medical costs." Stated differently, while the Department argues that the federal TPL provisions contemplate that the Medicaid program be fully reimbursed for medical costs that it paid on Ahlborn's behalf that were caused by the third party with whom she settled (without the Department's participation or agreement), Ahlborn argues that any portion of the compromise settlement that represents recovery for her non-medical claims (e.g., pain and suffering) is her "property" protected by the anti-lien provision.

Nothing in the statutory text speaks directly to how the federal TPL provisions operate in the context of a compromise settlement. Both the plain language of these statutes and Congress's expressed intent that Medicaid be the "payer of last resort," however, lead to the inescapable conclusion that the Medicaid program is to be reimbursed in full from the settlement proceeds for the entire amount of medical costs that were caused by the third party. Nothing in the language of the anti-lien provision supports Ahlborn's contention, which in effect would force the Medicaid program to accept a compromised value for its medical payments claim merely because Ahlborn chose to accept a compromise value for the remainder of her claim – a claim that she valued at nearly three million dollars.

A. The Plain Language Of The Federal TPL Provisions Reflect Congress's Intent To Create A Broad Right Of Reimbursement For The Medicaid Program

"The starting point in every case involving construction of a statute is the language itself." *Ernst & Ernst v. Hochfelder*, 425 U.S. 185, 197 (1976) (*quoting Blue Chip Stamps v. Manor Drug Stores*, 421 U.S. 723, 756 (1975) (Powell, J., concurring)). If the language of the statute is plain and unambiguous, the inquiry is at its end, "for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress." *Sullivan v. Stroop*, 496 U.S. 478, 482 (1990) (citation omitted). In the present case, the plain language of the federal TPL provisions instruct that when a third party is liable for a Medicaid recipient's medical expenses, the Medicaid program must be fully reimbursed for medical assistance payments made on behalf of the recipient before the

recipient may receive any remaining payment. There is nothing in the language of these statutes, nor in the anti-lien provision, that reflects a Congressional intent to limit the broad reach of the Medicaid program's recovery right.

Congress mandated in 42 U.S.C. § 1396a that states will "take all reasonable measures to ascertain the legal liability of third parties . . . to pay for care and services under the plan." 42 U.S.C. § 1396a(a)(25)(A). If such liability exists, states must "seek reimbursement [from the third party] for such assistance *to the extent of such legal liability.*" 42 U.S.C. § 1396a(a)(25)(B) (emphasis added). In furtherance of this recovery goal, the statute requires that states enact laws "under which, *to the extent that payment has been made* under the State plan for medical assistance for health care items or services furnished to an individual," the "State is considered to have acquired the rights" of the recipient to third party payments for these items or services." 42 U.S.C. § 1396a(a)(25)(H).

Likewise, Congress mandated that "[f]or the purpose of assisting in the collection of . . . payments for medical care owed to recipients of medical assistance," that State plans must provide that, "as a condition of eligibility for medical assistance under the State plan," a Medicaid applicant (or other person who has the legal capacity to execute an assignment on her behalf) "assign to the State any rights . . . to payment for medical care from any third party." 42 U.S.C. § 1396k(a) and (a)(1)(A). The statute likewise obligates Medicaid recipients to "assist the State in identifying, and providing information to assist the State in pursuing, any third party who may be liable to pay for care and services available under the plan." 42 U.S.C. § 1396k(a)(1)(C). Congress also established a payment priority in favor of the Medicaid program, instructing that

any amount collected pursuant to the assignment "shall be retained by the State *as is necessary to reimburse it for medical assistance payments made on behalf of the individual*," instructing that any remaining amount be paid to the recipient. 42 U.S.C. § 1396k(b).

In reading these TPL provisions together, one must conclude from their plain language that Congress intended to structure a mechanism whereby the Medicaid program would become entitled to payment for all medical costs from a third party who caused those expenses that the recipient could have recovered had she paid for the medical services herself. Such a reading not only is reasonable, but is consistent with Congress's intention that Medicaid be "the payer of last resort." Furthermore, nothing in the anti-lien statute suggests that Congress intended that Medicaid's broad recovery rights set forth in the TPL provisions be narrowed within the context of a compromise settlement.

The anti-lien provision, in relevant part, provides that "[n]o lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State [Medicaid] plan." 42 U.S.C. § 1396p(a)(1). Although Congress did not define the term "property," the Secretary did so in a regulation that applies to both 42 U.S.C. §§ 1396a and 1396p, as "the homestead of and all other personal and real property in which a recipient has a legal interest." 42 C.F.R. § 433.36(b) (2005). This definition lends no support to Ahlborn's argument that the anti-lien provision insulates that portion of a settlement that the recipient and third party designates as (or deems to be) recovery for something other than medical care from the reach of the federal TPL statutes.

It is highly unlikely that Congress intended "property" to have such a definition considering the legislative history, which shows a consistent trend toward strengthening the TPL provisions but contains no hint that the anti-lien provision insulates any portion of settlement proceeds from liable third parties from Medicaid reimbursement. A requirement that states identify third parties that might be liable to pay for a recipient's medical assistance was first added to the Act in 1968. *See* P.L. 90-248, § 229 (adding new subsection to Section 1902(a) of the Act [42 U.S.C. § 1396a(a)]). In 1977, Congress enhanced the ability of states to identify and collect from liable third parties by affording states *permission* to require an assignment as a condition of eligibility. *See* P.L. 142, § 12(b) (adding new Section 1912 to the Act [42 U.S.C. § 1396k]). Congress made this permissive assignment mandatory in 1984. *See* P.L. 98-369, § 2367(a) (adding new subsection to Section 1902 of the Act [42 U.S.C. § 1396a(a)] and amending Section 1912(a) to the Act [42 U.S.C. § 1396k]). Congress again strengthened the TPL provisions in 1986, with a related Senate Report expressing Congress's intent that "Medicaid is intended to be the payer of last resort." S. Rep. No. 99-146 at 279 (1985), *reprinted in* 1986 U.S.C.C.A.N. 42, 312, Pet. App. 44.

In 1993, Congress again amended the Act to add subsection (H) to 42 U.S.C. § 1396a(a)(25), which mandates that states have in effect laws under which they are considered to have acquired the rights of recipients to payment by any third party who is legally liable for the recipients' medical costs "to the extent that payment has been made under the State plan for medical assistance for health care items or services furnished." *See* P.L. 103-66, § 13622(c) (adding subsection (H) to Section 1902(a)(25) of

the Act [42 U.S.C. § 1396a(a)(25)(H)]). It is instructive that in that same legislation, Congress likewise made changes to the anti-lien provision but took no action that would suggest an intention to exclude any portion of a third party recovery from the scope of Medicaid's right to reimbursement. *See* P.L. 103-66, §§ 13611, 13622 (amending Sections 1917(b)-(e) of the Act [42 U.S.C. § 1396p(b)-(e)]).

Furthermore, because the Act requires that an individual assign to the State as a condition of Medicaid eligibility her right to "payment for medical care from any third party" liable for those expenses, 42 U.S.C. § 1396k(a)(1)(A), a Medicaid recipient no longer retains a property interest in the monies assigned. Rather, those monies become the property of the Medicaid program by operation of the assignment, and any lien placed upon them is not being placed upon property of the recipient, thus rendering the anti-lien provision irrelevant. This sound reasoning has been adopted by several courts, including the district court below. *See Wilson v. State*, 10 P.3d 1061, 1063 (Wash. 2000), *cert. denied*, 523 U.S. 1020 (2001); *Houghton v. Department of Health*, 57 P.3d 1067, 1069 (Utah 2002), *cert. denied*, 538 U.S. 945 (2003); *Cricchio v. Pennisi*, 683 N.E.2d 301, 305 (1997) and *Calvanese v. Calvanese*, 710 N.E.2d 1079, 1081-82 (N.Y. 1999), *cert. denied*, 528 U.S. 928 (1999). *But see Martin v. City of Rochester*, 642 N.W.2d 1, 13-14, 19 (Minn. 2002), *cert. denied*, 539 U.S. 957 (2003) (based upon federal third party liability statutes, state has assignment rights to "all proceeds for *medical care*, but does not have rights in any other part of recovery") (court's emphasis).

In *FDA v. Brown & Williamson Tobacco Corp.*, this Court recognized that due to the "fundamental cannon of statutory construction that the words of a statute must be

read in their context and with a view to their place in the overall statutory scheme," a court must "interpret the statute as a symmetrical and coherent regulatory scheme," and "fit, if possible, all parts into a harmonious whole." 529 U.S. 120, 133 (2000) (citations and internal quotations omitted). There is nothing in the anti-lien provision that reflects a Congressional intent to insulate any portion of a recipient's settlement with a liable third party from Medicaid recovery in the manner suggested by the court of appeals. Rather, a review of the overall statutory scheme of the Act reflects Congress's desire to replenish the Medicaid program by demanding full recovery from third parties who trigger program expenditures.[8]

Consistent with the federal TPL provisions, Arkansas law requires that applicants for Medicaid benefits must, "[a]s a condition of eligibility . . . automatically assign his or her right to any settlement, judgment, or award which may be obtained against any third party to [the Department] to the full extent of any amount which may be paid by Medicaid for the benefit of the applicant." Ark. Code Ann. § 20-77-307(a). It further provides that "[t]he assignment shall be considered a statutory lien on any settlement, judgment, or award received by the recipient from a third party." Ark. Code Ann. § 20-77-307(c). Thus, under Arkansas law, the lien does not attach to the recipient's "property" because it attaches only to those proceeds already assigned to the Department as a condition of Medicaid eligibility.

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[8] The third party liability recovery statutes do not apply only to tortfeasors, but likewise apply to reimbursement from third parties such as "health insurers, group health plans . . . and health maintenance organizations." 42 U.S.C. § 1396a(a)(25)(A).

B. Arkansas's Third Party Assignment and Recovery Laws, Which Were Enacted In Compliance With The Federal TPL Provisions, Do Not Violate The Federal Anti-Lien Provision

The court of appeals erred in concluding that Arkansas law runs afoul of the federal anti-lien provision. Initially, the court correctly recognized that the federal TPL provisions mandate that states require Medicaid applicant to assign some portion of third party settlement recoveries as a condition of Medicaid eligibility, and did not suggest that this federal assignment mandate was inconsistent with the anti-lien provision. Pet. App. 9, 10. For the reasons stated above, the court erred, however, in finding that these statutes are "limited to rights to third-party payments made to compensate for medical care." Pet. App. 10. Stated differently, the court of appeals concluded that the federal TPL provisions mandate that states require a Medicaid applicant to assign to the State Medicaid program *only* her right to payments from liable third parties that are designated as or represent payment for medical costs. This erroneous narrowing of the federal provisions thus tainted the court's view of the State's assignment and recovery provisions, resulting in the mistaken conclusion that Arkansas law overreached by demanding an assignment "to the full extent" of the amount paid by Medicaid for the benefit of the recipient. Had the court of appeals recognized the proper scope of the assignment mandate under federal law, it necessarily would have found that Arkansas's assignment provision was consistent with the federal law and thus not "pre-empted" by the federal anti-lien statute.

Next, the court of appeals erred in finding that Arkansas's assignment and recovery provisions forced Ahlborn to assign her unliquidated tort claim or "chose in action," as well as her "right to sue for damages," both of which the court deemed "property" under State law. The court failed to recognize, however, that Arkansas law did *not* require Ahlborn to assign her claim or her right to sue. To the contrary, Arkansas's assignment and recovery provisions expressly provide that a Medicaid recipient may prosecute her action "alone," Ark. Code Ann. § 20-77-302, with the only limitation being that "any settlement, judgment, or award obtained is subject to the [Department's] claim for reimbursement." Ark. Code Ann. § 20-77-302(a). Likewise, if the Department brings an action against a third party to recover medical assistance benefits paid to a recipient by the State Medicaid program, the law provides that "[n]o action taken on behalf of the [Department] . . . or any judgment rendered in the action shall be a bar to any action upon the claim or cause of action of the recipient . . . against the third person who may be liable for the injury," "[n]or shall any action [by the Department] operate to deny to the recipient the recovery for that portion of any damages not covered hereunder." Ark. Code Ann. § 20-77-301(b). Thus, Arkansas law does not authorize the Department to block a settlement or to overtake a recipient's personal injury cause of action; it merely enables the Department to recover from a liable third party the cost of the recipient's medical care paid for by the Medicaid program.

Additionally, the court of appeals failed to recognize that the federal TPL provisions and the compliant Arkansas law *do not* authorize the Medicaid program to seek reimbursement for medical costs paid by the program

unless those costs were caused by a liable third party. For example, if a Medicaid beneficiary wins the lottery or comes upon a large reward, the anti-lien provision would prohibit the program from placing a lien on those monies, regardless of the amount of benefits that the program had paid on the recipient's behalf.[9] Likewise, if Medicaid paid for a recipient's medical care that was *not* caused by a liable third party (e.g., annual preventive examinations, a fracture unrelated to a tortfeasor's conduct) in addition to medical care that was caused by a third party, the program could recover *only* those medical costs caused by the third party.[10] Like lottery winnings, medical costs unrelated to a liable third party's conduct would be a recipient's "property" protected by the anti-lien provision.

Next, the court of appeals incorrectly held that Arkansas law is adverse to the anti-lien provision because "the lien arises *after* Ahlborn receives her settlement from the tortfeasor." Pet. App. 6. In reaching this conclusion, the court turned to the language in Ark. Code Ann. § 20-77-307(c), which provides: "[t]he assignment shall be considered a statutory lien on any settlement, judgment, or award *received by the recipient from a third party.*" *Id.* Such a hyper-technical interpretation of the word "received" would be inconsistent with the purpose of both the state and federal TPL provisions, which is that Medicaid be reimbursed for medical expenditures made on behalf of recipients from the funds of third parties who are responsible for those

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[9] Of course, this increase in resources might disqualify the recipient from receiving future Medicaid benefits.

[10] In fact, it was for this reason that a downward adjustment was made to the amount that the State Medicaid program sought from Ahlborn. *See* Pet. App. 18, n.2.

expenditures. It is a fundamental principle of statutory construction "that the meaning of a word [not] be determined in isolation, but must be drawn from the context in which it is used." *Deal v. United States*, 508 U.S. 129, 132 (1993) (citations omitted).

Even if a Medicaid recipient does at some point in time have settlement proceeds in her possession, any portion of those proceeds that she previously assigned to the Department as a condition for Medicaid eligibility *is not her property.* Under Arkansas law, the Medicaid recipient is holding any such funds tendered directly to her in "constructive trust," which arises when a person holding property has an equitable duty to convey it to another. *See Waterall v. Waterall*, 155 S.W.3d 30, 33 (Ark. App. 2005). This duty to convey property arises when, among other situations, there has been a "wrongful disposition of another's property." *Id.* In fact, in the present case insurance carriers tendered $50,000.00 *directly* to Ahlborn. If one accepted the reasoning of the court of appeals that the anti-lien provision insulates a settlement recovery once it is placed in a recipient's hands, the Medicaid program would be rendered powerless in the present case to obtain reimbursement from any portion of this $50,000.00, *regardless* of Ahlborn's assignment.

Finally, for the reasons discussed below, the court's refusal to defer to the Secretary's interpretation of the Act was likewise erroneous.

II. The Secretary's Adjudications And Interpretations Addressing Medicaid, Which Is "A Complex And Highly Technical Regulatory Program," Are Entitled To Deference And Respectful Consideration

Although the plain language of the federal TPL provisions support the conclusion that Medicaid is entitled to full reimbursement from the settlement proceeds paid by a liable third party who caused the need for a recipient's medical care, Congress included nothing in the statutory text that speaks directly to how these provisions are to be implemented in the context of a compromise settlement. Any arguable ambiguity as to how these provisions intersect with the anti-lien provision presents the very type of "complex and highly technical" issue that the Congress has granted the Secretary "exceptionally broad authority" to address. *Wisconsin Dep't of Health & Family Services v. Blumer*, 534 U.S. 473, 497 (2002) (citations omitted).

Formal federal agency adjudications, such as those issued by Departmental Appeals Board ("Board") of the United States Department of Health and Human Services, are granted full deference when the language of a statute is ambiguous or silent on a particular issue and the interpretation is a permissible construction of the statute. *United States v. Mead Corp.*, 533 U.S. 218, 229 (2001) (citations omitted); *Chevron U.S.A. Inc. v. Natural Resources Defense Council*, 467 U.S. 837, 843 (1984). Agency interpretations not contained in regulations or adjudications, although not due the same degree of deference, are nonetheless due a "respect proportional to [their] 'power to persuade'" given the "'specialized experience and broader investigations and information' available to the agency." *Mead Corp.*, 533 U.S. 234-35 (*quoting Skidmore v. Swift & Co.*, 323 U.S. 134,

139-40 (1944)); *Wisconsin Dep't of Health & Family Services v. Blumer*, 534 U.S. 473, 497 and n.13 (2002).

A. The Departmental Appeals Board's Rulings That The Medicaid Program Is Entitled To Full Reimbursement Are Entitled To *Chevron* Deference.

In *United States v. Mead Corp.*, this Court recognized that a court should accord deference to an agency adjudication "when it appears that Congress delegated authority to the agency generally to make rules carrying the force of law, and that the agency interpretation claiming deference was promulgated in the exercise of that authority." 533 U.S. at 226-27. Such a delegation may be shown "in a variety of ways, as by an agency's power to engage in adjudication or notice-and-comment rulemaking." *Id.* at 227. In 42 U.S.C. § 1302(a), Congress authorized the Secretary to "make and publish such rules and regulations, not inconsistent with the [Social Security Act], as may be necessary to the efficient administration of the functions with which [it] is charged under [the] Act." This Court has "long noted Congress' delegation of extremely broad regulatory authority to the Secretary in the Medicaid area." *Wisconsin Dep't of Health & Family Services v. Blumer*, 534 U.S. 473, 497, n.13 (2002).

The Secretary has interpreted the operation of the federal TPL provisions in the context of third party settlements through formal adjudications by the Departmental Appeals Board ("Board").[11] Although the federal anti-lien

[11] The Board's basic process is to review a written record that both parties are "given ample opportunity to develop," which process may be

(Continued on following page)

provision was not directly at issue in these cases, it has been present in relevant part in the Act since 1965, thus leading to the reasonable conclusion that the Board was aware of the entire body of the Medicaid law at the time it rendered these decisions. Furthermore, the Board's reasoning transfers readily into the present context, as it reflects the broad scope of the federal TPL provisions.

In *California Dep't of Health Services*, HCFA (CMS's predecessor) had opposed California's practice of permitting recipients to keep portions of third party recoveries regardless of whether Medicaid was first fully reimbursed. DAB No. 1504, 1995 WL 66334 (Dep't of Health & Human Services, January 5, 1995), Pet. App. at 68, 69. The Board upheld HCFA's interpretation, concluding that federal Medicaid law requires full Medicaid reimbursement before a recipient may collect any proceeds from a third party settlement. App. at 69, 75. In so ruling, the Board concluded that HFCA's position was "directly supported" by the Act, explaining:

> [r]ecipients, as a condition of eligibility, must assign their rights to payment for medical care. States are then charged with the responsibility of seeking third party recovery pursuant to such assignments. States are further required to seek as much reimbursement as possible, i.e., to the extent of the third party's liability. Finally, when a recovery is made, the Act sets forth a distribution scheme which requires the Medicaid program to be reimbursed prior to distributing any funds to the recipient. While [42 U.S.C. § 1396k(a)] refers to

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supplemented by informal conferences or a hearing if deemed appropriate. 45 C.F.R. § 16.4 (2005).

> assignment only of "payment for medical care," the statutory scheme as a whole contemplates that the actual recovery might be greater and, if it is, that Medicaid should be paid first.

Pet. App. at 76. The Board also recognized that this position was not unfair to the Medicaid recipients, noting:

> [i]f Medicaid had not paid their medical expenses, these recipients would have both unrestricted access to their settlements and enormous medical debts to be paid from those settlements . . . where Medicaid has incurred the "debt" for recipients, it is not unfair for HCFA to require complete reimbursement from these liability funds.

Pet. App. at 85.

The Board rejected the State of California's argument that by demanding full Medicaid reimbursement for medical costs paid from third party settlement proceeds, HCFA "ignored the fact that these payments included amounts for things other than medical care." Pet. App. 80. The Board reasoned in part that Medicaid law, through the federal TPL provisions, looks to a third party that has caused the need for medical care "to reimburse the public." Pet. App. 80-81. Additionally, it noted that Medicaid recipients had received benefits only on the condition that the program would have a superior status to recover costs from any third party who is liable for those costs. Pet. App. 81. The Board also noted that characterizing recoveries from third parties first as payments for medical care "prevents manipulation of tort awards by recipients who seek to prevent the public from being reimbursed for the funds it has advance for their medical care," and that without such a characterization, "[third party liability]

recoveries would be subject to a wide range of interpretations about what was appropriately considered medical care." Pet. App. 81.

The Board reached a similar result the following year in *Washington State Dep't of Social & Health Services*, again upholding HCFA's determination that the federal TPL provisions mandate that Medicaid be reimbursed in full before a recipient may receive any third party settlement monies. DAB No. 1561, 1996 WL 157123 (Dep't of Health & Human Services, February 7, 1996), Pet. App. 45. The Board explained:

> Where there is a third party that is responsible for paying a recipient's medical expenses, the recipient may not recover money for him/herself until the federal government is reimbursed for its expenditure of the recipient's medical care . . . HCFA may require a state to assert a collection priority over funds obtained by Medicaid recipients in TPL suits even though the distribution methodology set forth in [42 U.S.C. § 1396k(b)] refers only to payments collected pursuant to assignments for medical care.

Id. at Pet. App. 54. Again, the Board stated unequivocally: "In cases where a third party has caused the need for medical care and is liable for its payment, the Act looks to that third party to reimburse the public." *Id.*

The court of appeals erred in not affording deference to these formal adjudications. Such a refusal is contrary to this Court's recognition of "Congress' delegation of extremely broad regulatory authority to the Secretary in the Medicaid area." *Wisconsin Dep't of Health & Family Services v. Blumer*, 534 U.S. 473, 496 n.13 (2002) (citations omitted). These formal adjudications likewise constitute "a

permissible construction of the [TPL] statute[s]," *Chevron*, 467 U.S. at 843, and advance Congress's intention that Medicaid be the "payer of last resort."

B. The Secretary's Interpretations Addressing The Relationship Between The Federal TPL And Anti-Lien Provisions Are Entitled To Respectful Consideration

Additionally, the Secretary (through HCFA/CMS) has repeatedly confirmed that the federal anti-lien provision does not prohibit states from placing liens on third party settlement proceeds to recover for medical assistance payments made by the Medicaid program to a recipient in cases where a liable third party has caused the need for the recipient's medical care. For example, in a letter to the states issued in June of 1988,[12] the HCFA instructed that a Medicaid recipient has a right "only to the remainder" of any recovery from a liable third party "after Medicaid payments are fully reimbursed." HCFA letter entitled "State Third Party Liability (TPL) Subrogation Legislation" (issued June 1, 1988), J.A. 28. Although this letter did not directly address the anti-lien provision, it emphasized HCFA's position that federal Medicaid law "does not authorize any payments to the recipient until Medicaid is fully repaid." J.A. 28. In reaching this conclusion, HCFA soundly reasoned that the federal TPL provisions mandate that a state is entitled to reimbursement for "what it paid

[12] In its Petition for Writ of Certiorari, the petitioner inaccurately indicated that this letter was issued in June of 1998 instead of 1988. This inaccuracy did not affect the reasoning set forth in the Petition, however.

on behalf of the recipient." J.A. 27, 28 (*citing* 42 U.S.C. §§ 1396a and 1396k).

In a letter issued by HCFA in September of 1994, the Secretary directly addressed the relationship between the federal TPL provisions and the anti-lien provision in the context of a recipient's settlement with or judgment against a liable third party. HCFA letter entitled "Third Party Liability Relationship to Liens" (issued September 2, 1994), J.A. 31-32. At bottom, HCFA noted that although federal law prohibits a state "from imposing liens against the property of an individual prior to his/her death because of medical assistance paid on his/her behalf," states are nonetheless required by the federal TPL provisions to seek reimbursement from a liable third party "for medical assistance payments already made" by the Medicaid program. J.A. 31. Recognizing that a recipient assigns to the state as a condition of Medicaid eligibility her rights to payment from any third party and likewise must cooperate with the state in the pursuit of any third party who might be liable for payment, HCFA explained that the state has a "claim to the amount recovered by [a] recipient" in a legal action against a third party "even though [the state] may not have been a party to the litigation." J.A. 32.

Specifically addressing the anti-lien provision, HCFA explained:

> If, under State law, a lien is not being placed upon the Medicaid recipient's property, but rather is being placed upon the tortfeasor's (the defendant in the personal injury litigation) property or upon funds which are set aside to be used in a settlement of the litigation, but which have not become the recipient's property, then there

> would be no conflict with [the anti-lien provision].
>
> . . .
>
> [states] have an interest in the potential personal injury settlement when a recipient's right to recover payment for medical care must have been assigned to [the state] . . . in order for him/her to be eligible for Medicaid. In that event, if you place a lien on these funds, it does not violate the [federal anti-lien] statute. However, you may not impose a lien on any of the recipient's property which has not been assigned to you.

J.A. 32.

The Secretary reiterated this position in a HCFA letter issued in June of 1996. HCFA letter entitled "Treating Disability Trusts Under Transfer Of Assets, Trust, Estate Recovery, and Third Party Liability Rules – INFORMATION (issued June 6, 1996), J.A. 31-32. In large part, the letter dealt with tightening of eligibility rules governing the use of trusts by Medicaid applicants. HCFA took this opportunity to once again expressly recognize a state's duty "to seek reimbursement for medical assistance payments already made," as well as a recipient's duty of cooperation in this regard and her initial assignment of rights as a condition of Medicaid eligibility. J.A. 36-37. Addressing the anti-lien provision, HCFA explained:

> If State laws permit, a State can place a lien upon a third party's property, as in a situation involving the property of a tortfeasor or defendant in a personal injury suit, or upon funds which are set aside to be used in a settlement, but which have not yet become the property of the Medicaid applicant or recipient.

> [the anti-lien provision] precludes States from placing liens on individual's property. However, because a potential personal injury settlement is not yet the plaintiff's property, it can be subject to a TPL lien.

J.A. 37-38.

This Court has long recognized that informal policy interpretations by an agency charged with the administration of a statute are entitled to some level of deference as long as they are informed, reasonable, and persuasive. *See Skidmore v. Swift & Co.*, 323 U.S. 134, 140 (1944); *see also Christensen v. Harris County*, 529 U.S. 576, 587 (2000); *United States v. Mead Corp.*, 533 U.S. 218, 227-35 (2001). Policy statements and guidelines addressing the administration of a federal program, "while not controlling upon the courts by reason of their authority, do constitute a body of experience and informed judgment to which courts and litigants may properly resort for guidance." *Skidmore*, 323 U.S. at 140. "[A]n agency's interpretation may merit some deference whatever its form, given the 'specialized experience and broader investigations and information' available to the agency," and "given the value of uniformity in its administrative and judicial understandings of what a national law requires." *Mead Corp.*, 533 U.S. at 234 (*citing Skidmore*, 323 U.S. at 139-40).

In *Wisconsin Dep't of Health & Family Services v. Blumer*, this Court addressed the level of deference accorded to interpretations of the United States Secretary of Health and Human Services in the context of the Medicaid program. 534 U.S. 473 (2002). In *Blumer*, this Court held that Wisconsin's use of an "income first" method, which the Secretary had specifically authorized in a "Regional State Letter," was a permissible approach under federal

law for determining an institutionalized spouse's Medicaid eligibility. Upholding the State's method, this Court found that the Secretary's position warranted "respectful consideration," which it found was "particularly appropriate" within the Medicaid context due to the Secretary's "significant expertise" in "a complex and highly technical regulatory program." *Id.* at 497 (citations omitted). In so ruling, this Court also recognized the long-standing principle that Congress delegated "extremely broad regulatory authority to the Secretary in the Medicaid area." *Id.* at 497 n.13. (citations omitted).

The court of appeals erred in refusing to afford any value to the view of the Secretary that the federal anti-lien provision does not prohibit states from placing liens on third party settlement proceeds to recover medical assistance payments made by the Medicaid program to a recipient. The Secretary's reasoning is persuasive and well-grounded in the plain language of the federal TPL and anti-lien statutes. Additionally, the legislative history strongly supports the persuasiveness of this view, considering that Congress intended Medicaid to be the "payer of last resort."

III. Full Reimbursement Of The Medicaid Program Is Preferable From A Policy Standpoint

Sound policy considerations likewise militate in favor of full Medicaid reimbursement in the third party liability context. This is particularly true at a time when the level of federal funding of the Medicaid program is decreasing. Full program reimbursement is not only mandated by the federal TPL provisions, but also will enhance the fiscal viability of the program. Medicaid dollars are far from

being an endless resource, and money reimbursed to the program from liable third parties may be used to aid other Medicaid applicants in need.

First, the position advanced by the court of appeals would place the Medicaid program in the untenable position of being treated less favorably than for-profit health care providers. If a person who is not receiving Medicaid benefits is injured by a third party, that individual remains liable to his or her medical providers for the full amount of medical services provided. Any interpretation of the TPL and anti-lien provisions that would allow a Medicaid recipient to receive medical care at public expense and subsequently keep funds recovered from a third party who triggered those costs – as opposed to having those funds returned to the Medicaid program and thus the taxpaying public – is antithetical to Congress's intent that Medicaid be the payer of last resort.

For example, assuming *arguendo* that Ahlborn had not applied for Medicaid benefits but rather had accumulated medical costs at or near $215,645.30 as a result of her accident, she would be obligated to reimburse her medical providers for that *entire amount* from any settlement proceeds. There is absolutely no reason why she should not have to likewise reimburse the Medicaid program. In enacting the TPL and anti-lien provisions, Congress surely did not intend that Medicaid receive such disparate, unfavorable treatment, nor did it intend that the recipient receive a windfall at the expense of other Medicaid applicants and the taxpaying public. Moreover, as the Departmental Appeals Board recognized in *California Dep't of Health Services*, a requirement that the Medicaid program be completely reimbursed from settlement proceeds is not unfair to recipients because, "[i]f

Medicaid had not paid their medical expenses . . . recipients would have both unrestricted access to their settlements and enormous medical debts to be paid from those settlement proceeds. As Medicaid recipients, they do not have such debts because the public has paid their medical expenses." DAB No. 1504, 1995 WL 66334 (Dep't of Health & Human Services, January 5, 1995), Pet. App. at 68, 85.

Second, it is incongruous to argue on one hand that Ahlborn's resources were so limited at the time of her accident that she qualified for publicly funded medical benefits for the "needy," but on the other hand that she retained a property interest – insulated from the federal TPL reimbursement mandate – in those portions of a personal injury settlement that she and a third party designate as or consider to be something other than recovery for medical care. Such an argument creates "an anomalous situation in which Medicaid applicants could be disqualified from eligibility for financial resources that include prior personal injury settlements allocated to pain and suffering, but Medicaid recipients could shield such funds from recoupment by the [Medicaid program] after having received significant public assistance." *Calvanese v. Calvanese*, 710 N.E.2d 1079, 1082 (N.Y. 1999), *cert. denied*, 528 U.S. 928 (1999). Ahlborn's argument, which constitutes the proverbial "having your cake and eating it too," ignores the reality that the Medicaid program paid Ahlborn's medical bills and is now merely seeking to be paid back by the third party who caused those costs in the first instance.

Third, Ahlborn's position would force states to intervene in all ongoing litigation or to file independent causes of action against third party tortfeasors to recover Medicaid program expenditures. And as the present case shows,

even intervention does not always lead to satisfactory reimbursement results. Increased state participation in litigation will result in a substantial increase in expenditures of staff time and financial resources by the states. At bottom, requiring states to pursue third parties directly to recover publicly funded medical costs, instead of using lien or subrogation statutes, would force states to spend much more money to recover the same amount of funds, thereby leaving less money to return to the Medicaid program for use by Medicaid applicants in need.

Finally, Ahlborn's approach would promote manipulation in the apportionment of recoveries by the parties. As the district court below correctly reasoned, "adopting the approach advocated by [Ahlborn] would encourage manipulation of the allocation of settlement amounts," and would likewise "place upon States the additional burden of proving up the past medical expense component of a compromise settlement or challenging the allocation made by others with no interest in placing an appropriate value on that component of recovery." Pet. App. 30-31. This concern is shared by the Departmental Appeals Board, which explained in a case involving a Medicaid recipient's settlement recovery from a liable third party:

> HCFA reasonably insisted on its right to characterize recoveries from third parties first as payments for medical care. This characterization prevents manipulation of tort awards by recipients who seek to prevent the public from being reimbursed for the funds it has advanced for their medical care (e.g., by suing for pain and suffering or lost wages rather than for medical costs). Without it, TPL recoveries would be subject to a wide range of interpretations about what

was appropriately considered payment for medical care.

California Dep't of Health Services, DAB No. 1504, 1995 WL 66334 (Dep't of Health & Human Services, January 5, 1995), Pet. App. at 68, 81.[13]

CONCLUSION

For the reasons and based upon the authorities set forth above, the Petitioners respectfully request that the judgment of the court of appeals be reversed.

Respectfully submitted,

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[13] This manipulation concern would be absent if the recipient's claim was tried to a judge or jury that apportioned any recovery between damages for medical costs versus those for non-medical cost elements of the recipient's claim. In the trial context, the fact finder would determine "the extent of [the third party's] legal liability," *see* 42 U.S.C. § 1396a(a)(25)(B), or the amount of "payments for medical care owed to the recipient" by the third party, *see* 42 U.S.C. § 1396k(a). Thus, the Medicaid program would receive from the total recovery the amount awarded for medical costs. If the judge or jury does not apportion damages, however, the federal TPL provisions mandate that the Medicaid program will receive full reimbursement from the total award before the recipient may be paid the remainder. *See* 42 U.S.C. § 1396k(b).

APPENDIX

42 U.S.C. § 1396. Appropriations.

For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this subchapter. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary, State plans for medical assistance.

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42 U.S.C. § 1302. Rules and Regulations; Impact Analyses of Medicare and Medicaid Rules and Regulations on Small Rural Hospitals.

(a) The Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health and Human Services, respectively, shall make and publish such rules and regulations, not inconsistent with this chapter, as may be necessary to the efficient administration of the functions with which each is charged under this chapter.

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42 C.F.R. § 430.10. The State plan.

The State plan is a comprehensive written statement submitted by the agency describing the nature and scope

of its Medicaid program and giving assurance that it will be administered in conformity with the specific requirements of title XIX, the regulations in this Chapter IV, and other applicable official issuances of the Department. The State plan contains all information necessary for CMS to determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State program.

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42 C.F.R. § 433.36. Liens and recoveries.

(a) Basis and purpose. This section implements sections 1902(a)(18) and 1917(a) and (b) of the Act, which describe the conditions under which an agency may impose a lien against a recipient's property, and when an agency may make an adjustment or recover funds in satisfaction of the claim against the individual's estate or real property.

(b) Definition of property. For purposes of this section, "property" includes the homestead and all other personal and real property in which the recipient has a legal interest.

* * *

---

45 C.F.R. § 16.4. Summary of procedures below.

The Board's basic process is review of a written record (which both parties are given ample opportunity to develop), consisting of relevant documents and statements submitted by both parties (see § 16.8). In addition, the Board may hold an informal conference (see § 16.10). The informal conference primarily involves questioning of the participants by a presiding Board member. Conferences

may be conducted by telephone conference call. The written record review also may be supplemented by a hearing involving an opportunity for examining evidence and witnesses, cross-examination, and oral argument (see § 16.11). A hearing is more expensive and time-consuming than a determination on the written record alone or with an informal conference. Generally, therefore, the Board will schedule a hearing only if the Board determines that there are complex issues or material facts in dispute, or that the Board's review would otherwise be significantly enhanced by a hearing. Where the amount in dispute is $25,000 or less, there are special expedited procedures (see § 16.12 of this part). In all cases, the Board has the flexibility to modify procedures to ensure fairness, to avoid delay, and to accommodate the peculiar needs of a given case. The Board makes maximum feasible use of preliminary informal steps to refine issues and to encourage resolution by the parties. The Board also has the capability to provide mediation services (see § 16.18).

Supreme Court, U.S.
FILED
JAN 12 2006
OFFICE OF THE CLERK

No. 04-1506

In The Supreme Court of the United States

ARKANSAS DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,

Petitioners,

vs.

HEIDI AHLBORN,

Respondent.

CORRECTED COPY

On Writ Of Certiorari To The United States Court Of Appeals For The Eighth Circuit

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QUESTION PRESENTED

Whether 42 U.S.C. §1396p(a)(1) permits a state Medicaid program to appropriate a recipient's monetary recovery on a claim arising out of personal injury beyond the extent to which it represents compensation for past medical expenses.

TABLE OF CONTENTS

	Page
QUESTION PRESENTED	i
TABLE OF AUTHORITIES	iii
STATEMENT OF THE CASE	1
SUMMARY OF ARGUMENT	3
ARGUMENT	7
I. Ahlborn's Cause of Action Against the Parties Responsible For Her Injuries And Damages Constituted "Property"	7
II. Other Federal Statutes Do Not Conflict With the Anti-Lien Statute	8
III. The Arkansas Statutes Conflict With The Anti-Lien Statute	13
IV. The Anti-Lien Statute Is Unambiguous	15
V. The HHS Adjudications Are Not Entitled To Deference	17
CONCLUSION	19

TABLE OF AUTHORITIES

Page

FEDERAL CASES

Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc., 467 U.S. 837 (1984) 6, 17, 19

Christensen v. Harris County, 529 U.S. 576 (2000) 19

Exxon Mobile Corporation v. Allapattah Services, Inc., ___ U.S. ___, 125 S.Ct. 2611 (2005) 16

Gibbes v. Zimmerman, et al., 290 U.S. 326 (1933) 7

Pritchard v. Norton, 106 U.S. 124, 1 S.Ct. 102 (1882) 7

United States v. Craft, 535 U.S. 274 (2002) 8

STATE CASES

Calvanese v. Calvanese, 93 N.Y.2d 111, 688 N.Y.S. 2d 479, 710 N.E.2d 1079 (1999), *cert. denied*, 528 U.S. 928 (1999) 12

Gregory v. Colvin, 235 Ark. 1007, 363 S.W.2d 539 (1963) 7

Grey Bear v. North Dakota Dept. of Human Serv., 202 N.D. 139, 651 N.W.2d 611 (2002), *cert. denied*, 539 U.S. 960 (2003) 12

Houghton v. Department of Health, 202 Ut. 101, 57 P.3d 1067 (2002), *cert. denied*, 538 U.S. 945 (2003) 12

Martin v. City of Rochester, 642 N.W.2d 1 (Minn. 2002), *cert. denied*, 539 U.S. 957 (2003) 12, 13

TABLE OF AUTHORITIES – Continued

Page

DECISIONS OF THE DEPARTMENT OF APPEALS BOARD, UNITED STATES DEPARTMENT OF HEALTH & HUMAN SERVICES

California Dep't. of Health Services, DAB No. 1504, 1995 WL 66334 (Dep't of Health & Human Services January 5, 1995) 18

Washington State Dep't of Social & Health Services, DAB No. 1561, 1996 WL 157123 (Dep't of Health & Human Services February 7, 1996) 17, 18

FEDERAL REGULATIONS

42 C.F.R. §433.36(b) 7

FEDERAL STATUTES

42 U.S.C. §1396-1396v 9

42 U.S.C. §1396a(a)(25)(B) 17

42 U.S.C. §1396a(a)(25)(H) 5, 6, 9, 18

42 U.S.C. §1396k(a)(1)(A) 5, 6, 9, 18

42 U.S.C. §1396p(a)(1) 2, 3, 7, 8

STATE STATUTES

Ark. Code Ann. §20-77-302(a) 13

Ark. Code Ann. §20-77-302(b) 14

Ark. Code Ann. §20-77-307 13

Ark. Code Ann. §20-77-307(a) 1

Ark. Code Ann. §20-77-307(c) 4, 14

STATEMENT OF THE CASE

Due to a motor vehicle accident, Heidi Ahlborn, then nineteen years of age, sustained serious and disabling personal injuries, especially to her head, resulting in extensive medical treatment and permanent disability. Subsequently, she was determined to be eligible for Medicaid benefits which were then provided by the Arkansas Department of Human Services, the state agency responsible for the administration of the Medicaid program. Arkansas law specified that Ahlborn automatically assigned to the Arkansas Department of Human Services her "right to any settlement, judgment, or award" she might receive from responsible third parties "to the full extent of any amount which may be paid by Medicaid for the benefit of the applicant." Ark. Code Ann. §20-77-307(a). J.A. 22, 46, 47, 48.

Ahlborn brought suit against two alleged tortfeasors and made a claim against her underinsured motorist carrier. After protracted litigation, the tort claims were settled for a total of $525,000.00. The underinsured motorist carrier paid its limits of $25,000.00, making a total recovery of $550,000.00. J.A. 18. The Arkansas Department of Human Services asserted its lien in the amount of $215,645.30, for which it claimed a right of reimbursement in full. J.A. 12.

A controversy developed between Ahlborn and the state agency as to the permissible extent of the state's right of recoupment. It was stipulated by the DHS that absent any considerations of liability, Ahlborn's cause of action was reasonably estimated at $3,040,708.12 and that the proceeds of the compromise settlement represented

approximately 16.5% of the estimated value of her total damages. J.A. 5, 18.

Ahlborn filed a declaratory judgment action in the District Court contending that 42 U.S.C. §1396p(a)(1) (commonly referred to as the anti-lien statute), prohibits the imposition of a lien "against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the state plan[.]", thereby limiting DHS's statutory right of reimbursement to that portion of the lump-sum settlement which fairly represented the past medical expense component of the recovery. J.A. 5-6. It was stipulated by DHS that if Ahlborn was correct, that the DHS lien would be limited to recovering $35,581.47, the amount of the percentage fairly attributable to the past medical expense portion of her claim. J.A. 18.

Both parties filed motions for summary judgment. Pet. App. 16. DHS contended that there was no conflict with the anti-lien statute since under the automatic statutory assignment, Ahlborn's entire claim did not become her property until the Medicaid lien was satisfied. Pet. App. 22.

The District Court granted DHS's motion for summary judgment. Pet. App. 31. The District Court held that the anti-lien statute was not violated because Ahlborn had automatically assigned her right to payment from third parties and any funds she received were not her property. Pet. App. 28-29. The Eighth Circuit Court of Appeals reversed holding that monies received by Ahlborn which were not reimbursements for medical expenses paid were

her property and protected by the anti-lien statute. Pet. App. 14, 15.

SUMMARY OF THE ARGUMENT

42 U.S.C. §1396p(a)(1) prohibits the imposition of a lien "against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the state plan[.]" This statute, commonly referred to as the "anti-lien" statute, prevented Arkansas' statutory right of reimbursement except for that portion of the lump-sum settlement which fairly represented the past medical expense component of a tort recovery.

Under both state and federal law, Ahlborn's cause of action against the parties responsible for her injuries constitutes "property". Although Arkansas had enacted a law which automatically assigned to DHS all portions of a Medicaid recipient's recovery, the supremacy clause prohibits its application to the extent that it attempts to acquire monies received by the Medicaid recipient in excess of those amounts recovered for medical care or treatment.

Ahlborn's cause of action consisted of much more than a recovery of medical expenses. Her cause of action included loss of earnings and earning capacity, pain, suffering and permanent impairment of the ability to earn in the future. It was stipulated by DHS that absent any consideration of liability, a reasonable estimation of Ahlborn's damages would be $3,040,708.12. It was further stipulated by DHS that $35,581.47 is a fair representation of the percentage of the total settlement constituting

payment by the tortfeasor for past medical care. Under the "anti-lien" statute, that is the amount that the state is limited to recovering from Ahlborn's settlement.

DHS recognizes that the "anti-lien" statute would prohibit Medicaid from seeking reimbursement for medical costs paid by the program regardless of the amount of money that a Medicaid beneficiary received from any outside source with the exception of those costs which were incurred due to the fault of a liable third party. Even if a recipient were to inherit large sums of money or win the lottery, DHS agrees that Medicaid could not seek reimbursement for medical expenses already paid because such recovery would be prohibited by the anti-lien statute. It would be incongruous for Congress to prohibit the recovery of medical expenses paid by Medicaid out of lottery winnings but allow recovery of amounts paid for a recipient's permanent disability.

The state contends that there is no conflict with the anti-lien statute concerning recoveries from third parties because under the automatic assignment statute, the money remained the property of the tortfeasor until the state was fully reimbursed for all funds expended for Ahlborn's medical care. The automatic assignment statute states, "the assignment shall be considered a statutory lien on any settlement, judgment or award *received by recipient from a third party*". Ark. Code Ann. §20-77-307(c). (emphasis added). This language presumes that Ahlborn receives the property before it is assigned. The assignment statute seeks to relieve Ahlborn of her property and clearly violates the anti-lien provision. Without the anti-lien statute, there would be no prohibition on the state from imposing such an assignment on any Medicaid

recipient whether receiving property from a liable third party or a wealthy aunt.

The federal anti-lien statute does not conflict with other federal Medicare statutes which require the states to acquire reimbursements from third parties and assign to the states damages paid from third parties.

42 U.S.C. §1396a(a)(25)(H) provides:

A State plan for medical assistance must –

. . .

(25) provide –

. . .

(H) that to the extent that payment has been made under the State plan for medical assistance in any case where *a third party has a legal liability to make payment for such assistance*, the State has in effect laws under which, to the extent that payment has been made under the State plan for medical assistance for health care items or services furnished to an individual, the State is considered to have acquired the rights of such individual *to payment by any other party for such health care items or services.* (emphasis added)

42 U.S.C. §1396k(a)(1)(A) provides:

(a) For the purpose of assisting in the collection of medical support payments . . . a State plan for medical assistance shall –

(1) provide that, as a condition of eligibility for medical assistance . . . to an individual . . . the individual is required –

> (A) to assign the State any rights . . . *to payment for medical care from any third party* . . .

These statutes only require the State to recover those portions of payments made for medical expenses. Under 42 U.S.C. §1396a(a)(25)(H), the State only acquires the right of the beneficiary "to payment by any other party for such health care items or services." 42 U.S.C. §1396k(a)(1)(A) limits the beneficiary's assignment of rights to the State "to payment for medical care from any third party". Any state law which exceeds these boundaries is preempted by the federal anti-lien statute.

Although there have been opinions by the Department of Human Services that allow the states to recover from beneficiaries more than those amounts tortfeasors paid for medical care, they are not entitled to *Chevron* deference because the anti-lien statute is not ambiguous. *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842-843, 104 S.Ct. 2778, 81 L.Ed.2d 694 (1984). All three federal statutes limit the recovery of the state to payments for medical care. The anti-lien statute cannot be more direct in its meaning and there is no necessity for an agency determination.

Because the anti-lien statute is unambiguous, there is no need to examine the legislative history of the act in an attempt to determine Congressional intent. An unambiguous statute needs no such examination. Congressional intent on protecting the property of Medicaid beneficiaries has been long standing. While it may be that Congress could not consider every eventuality under which the anti-lien statute might operate, its wording of the statute was absolute.

The state retains its ability to recover its costs expended from liable third-party tortfeasors. Neither the anti-lien statute nor any of the other federal statutes prohibit the state from pursuing its cause of action independently. Even though the anti-lien statute applies in a narrow area, should the enforcement of its provisions prove overly burdensome to Medicaid, Congress can always change the terms of all three applicable statutes as it wishes.

ARGUMENT

I. Ahlborn's Cause of Action Against the Parties Responsible For Her Injuries And Damages Constituted "Property"

Ahlborn contends that the federal anti-lien statute, 42 U.S.C. §1396p(a)(1) prohibits (with certain exceptions not applicable here) the imposition of a lien "against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the state plan[.]" The first consideration therefore must be whether Ahlborn's claim for personal injuries, and any recovery for those injuries, constituted property. In Arkansas, "it is basic property law that a chosen action is personal property. The right to sue for damages is property." *Gregory v. Colvin*, 235 Ark. 1007, 1008, 363 S.W.2d 539-540 (1963). This Court has further recognized that a vested cause of action is property. *Pritchard v. Norton*, 106 U.S. 124-132, 1 S.Ct. 102 (1882), *Gibbes v. Zimmerman*, et al., 290 U.S. 326-331 (1933). Federal Medicaid regulations define property as "the homestead and all other personal and real property in which the recipient has a legal interest." 42 C.F.R. §433.36(b). Ahlborn's cause of action against

the tortfeasors responsible for her injuries and damages was therefore personal property in which she had a legal interest.

Ahlborn's cause of action was stipulated to encompass various elements of damage which are generally recognized by most jurisdictions. In Arkansas, they include pain and suffering and permanent disability including loss of earnings and loss of earning capacity. These elements of damage have commonly been referred to as a "bundle of sticks". *United States v. Craft*, 535 U.S. 274, 278 (2002).

The State stipulated that Ahlborn's cause of action less any considerations of liability had a value of $3,040,707.12. J.A. 18-19. The parties further agreed that of the $550,000.00 recovered, $35,581.47 represented the recovery for past medical expenses. Therefore, should Ahlborn prevail on the issue of statutory construction, Medicaid's reimbursement would be limited to $35,581.47. Should the State prevail on the issue of statutory construction, Medicaid would be reimbursed for the full amount of medical expenses paid in the amount of $215,645.30. *Id.*

II. Other Federal Statutes Do Not Conflict With The Anti-Lien Statute

42 U.S.C. §1396p(a)(1) provides that Ahlborn's property may not have a lien imposed upon it because of her receipt of Medicaid benefits. Is there an exception created by federal law for the State to attach a lien to Ahlborn's property?

The Medicaid program was established in 1965 in order to help states reimburse cause of medical treatment

for individuals who came within the poverty guidelines. The program was created by Title XIX of the Social Security Act modified at 42 U.S.C. §1396-13396v.

As a condition for participating in the Medicaid program, Congress enacted statutes requiring the states to attempt recovery of Medicaid funds against the parties responsible for the beneficiary's injuries necessitating the medical treatment.

42 U.S.C. §1396a(a)(25)(H) provides:

> A State plan for medical assistance must –
>
> . . .
>
> (25) provide –
>
> . . .
>
> (H) that to the extent that payment has been made under the State plan for medical assistance in any case where *a third party has a legal liability to make payment for such assistance*, the State has in effect laws under which, to the extent that payment has been made under the State plan for medical assistance for health care items or services furnished to an individual, the State is considered to have acquired the rights of such individual *to payment by any other party for such health care items or services.* (emphasis added).

The second statute, 42 U.S.C. §1396k(a)(1)(A) states:

> (a) For the purpose of assisting in the collection of medical support payments . . . a State plan for medical assistance shall –

> (1) provide that, as a condition of eligibility for medical assistance . . . to an individual . . . the individual is required –
>
> (A) to assign the State any rights . . . *to payment for medical care from any third party;*
>
> . . .
>
> (C) to cooperate with the State in identifying and providing information to assist the State in pursuing any third party *who may be liable to pay for care and services available under the plan* . . . (emphasis added)

These two statutes allow the states to recoup money expended for the medical care of the Medicaid beneficiary. The issue presented by this case is the extent to which Congress allowed reimbursement, either from the beneficiary or a responsible third party in cases where the recovery was less than adequate to fully reimburse the state and compensate the beneficiary for the other elements of damage beyond past medical expenses. Obviously, when there has been a recovery which fully compensates the State and the Medicaid beneficiary, there is no problem.

The Amicus brief filed by the Solicitor General of the United States is rife with suggestions that Ahlborn's failure to place the Arkansas Department of Human Services on notice of a proposed settlement with the tortfeasor prejudiced the Department's position with regard to its lien. Solicitor General's Brief, 9, 14, 15, 21 and 22. Such notice would have accomplished no purpose. The Arkansas Attorney General recognizes that the State is powerless to stop a beneficiary from settling her case. Pet. Brief, 33. While there are insufficient funds to compensate

both Ahlborn and the Arkansas Department of Human Services, there has always been an agreement by the parties to hold out of the total recovery of $550,000.00 sufficient funds to satisfy in full the lien of the Department of Human Services in the amount of $215,645.30 should the Department prevail on its argument before this Court. Such lack of notification in this case is of no consequence.

It is further alleged by the Solicitor General that Ahlborn manipulated the percentage that her medical expenses bore to the total amount of recovery. Solicitor General's Brief, 13, 23. The total value of Ahlborn's claim and the medical expense percentage were stipulated by the Arkansas Department of Human Services. J.A. 18-19.

It is Ahlborn's contention that the emphasized statutory phrases above are the only exceptions to the anti-lien statute in which the State may seek reimbursement from either Ahlborn herself or from a third party. All other attempts at reimbursement are pre-empted.

Ahlborn contends that the emphasized language in both statutes limits the State's recovery to only those amounts recovered for her medical care and that the anti-lien statute prohibits the State from recovering funds which were paid for Ahlborn's other elements of damages. In a very well-reasoned opinion by the Eighth Circuit Court of Appeals, the statutory construction limited the State's recovery. The Court stated:

> We believe a straightforward interpretation of the text of these statutes demonstrates that the federal statutory scheme requires only that the State recover payments from third parties to the extent of their legal liability to compensate the

> beneficiary *for medical care and services* incurred by the beneficiary. Under §1396a(a)(25)(H), a state Medicaid plan must include provisions specifying that, when the State provides medical benefits to an applicant, "the State is considered to have acquired the rights of such individual to *payment by any other party for such health care items or services*." (emphasis added). This acquisition of rights occurs only in cases where "a third party has a legal liability to make payment for [medical] assistance." *Id.* Section 1396k(a)(1)(A) similarly requires that an applicant assign to the State her right "*to payment for medical care* from any third party." (emphasis added). Both statutes are thus limited to rights to third-party payments made to compensate for medical care. Pet. App. 9-10.

The Eighth Circuit's opinion approved the finding of the Supreme Court of Minnesota in *Martin v. City of Rochester*, 642 N.W.2d 1 (Minn. 2002), *cert. denied*, 539 U.S. 957 (2003) which recognized that the anti-lien statute protected the property of the Medicaid recipient in the form of her cause of action, but also assigned to the State the right to recover in full from a responsible third party for medical expenses paid. Pet. App. 10.

While there are cases to the contrary of the Eighth Circuit decision and *Martin*, some do not deal directly with the anti-lien statute. *Calvanese v. Calvanese*, 93 N.Y.2d 111, 688 N.Y.S. 2d 479, 710 N.E.2d 1079 (1999), *cert. denied*, 528 U.S. 928 (1999); *Grey Bear v. North Dakota Dept. of Human Serv.*, 202 N.D.139, 651 N.W.2d 611 (2002), *cert. denied*, 539 U.S. 960 (2003). Others give only superficial consideration to the anti-lien statute. *Houghton v. Department of Health*, 202 Ut. 101, 57 P.3d 1067 (2002), *cert. denied*, 538 U.S. 945 (2003).

Ahlborn submits that *Martin* and the Eighth Circuit opinion constitute the better rule of law on the issue presented. Congress did not intend for the State's assignment for recovery purposes to delve into the beneficiary's recovery for damages in excess of past medical expenses paid. To do so would countenance placing a lien on the beneficiary's property in violation of the anti-lien statute.

III. The Arkansas Statutes Conflict With The Anti-Lien Statute

Arkansas passed two statutes in an attempt to follow Congress' mandate to recover Medicaid expenses paid. The automatic assignment statute provides:

> As a condition of eligibility, every Medicaid applicant shall automatically assign his or her right to any settlement, judgment or award which may be obtained against any third party to the Department of Human Services to the full extent of any amount which may be paid by Medicaid for the benefit of the applicant. (b) The application for Medicaid benefits shall, in itself, constitute an assignment by operation of law. (c) The assignment shall be considered statutory lien on any settlement, judgment, or award received by the recipient from a third party. Ark. Code Ann. §20-77-307.

Ark. Code Ann. §20-77-302(a) provides:

> When an action or claim is brought by a medical assistance recipient or his or her legal representative against a third party who may be liable for injury, disease, disability, or death of a medical assistance recipient, any settlement, judgment, or award obtained is subject to the division's

> claim for reimbursement of the benefits provided to the recipient under the medical assistance program. (b) In the event of judgment or award in a suit or claim against a third party, if the action or claim is prosecuted by the recipient alone, the court or agency shall first order paid from any judgment or award, the reasonable litigation expenses and attorney's fees. After the payment of these expenses and attorney's fees, the court or agency shall order that the Department of Human Services receive an amount sufficient to reimburse the department the full amount of benefits paid on behalf of the recipient under the medical assistance program. The remainder shall be awarded to the medical assistance recipient.

These statutes do not limit the amount of the State's recovery to that portion covered for the Medicaid beneficiary's medical expenses. To the extent that they allow recovery beyond that amount, they are pre-empted by the anti-lien statute and are therefore invalid.

By its language, Ark. Code Ann. §20-77-307(c) creates the lien after the Medicaid recipient receives the "settlement, judgment, or award" from a third party. The State argues that the recovery remained the property of the tortfeasor and never became Ahlborn's property. The statutory language indicates that the recovery has become Ahlborn's property before the lien attaches placing it in clear violation of the anti-lien statute:

> "(c) The assignment shall be considered a statutory lien on any settlement, judgment, or award *received* by the recipient from a third party." *Id.* (emphasis added)

The State cannot accomplish indirectly by what it cannot do directly. Congress did not intend that the State

could accomplish by statutory assignment what it could not accomplish by placing a lien on the property of the beneficiary. The Arkansas statutes were enacted without Congressional authority and create an exception to Congressional directives. If Congress had intended the assignment to be an exception to the anti-lien law, it could have so stated as incongruous as that may have been. As the Eighth Circuit pointed out:

> We do not believe, moreover, that the State may circumvent the restrictions of the federal anti-lien statute simply by requiring an applicant for Medicaid benefits to assign property rights to the State before the applicant liquidates the property to a sum certain. If the State could proceed in that manner, then we do not see what limiting principal would preclude the State from requiring a Medicaid applicant to assign to the State other interests and property – such as future wages, lottery winnings, or real property – in order to reimburse the State for health care expenditures under Medicaid. This sort of broad ranging assignment requirement clearly would conflict with the federal anti-lien statute. Pet. App. 6-7.

IV. The Anti-Lien Statute Is Unambiguous

It has been argued that the legislative history of the anti-lien statute suggests that third party recoveries were not in contemplation of Congress when the act was passed. The statute is unambiguous and specifically covers all of Medicaid beneficiary's property and not merely housing. Had Congress chosen to exclude property other than houses, it could have so stated. The Amicus brief by the Attorney General of the State of Washington urges the

Court to examine the legislative tea leaves in order to reach a conclusion other than that clearly stated by the Congress. It is unnecessary to resort to clairvoyant attempts to read the mind of Congress when Congress' intent is clearly stated. This Court has recognized that such an attempt carries inherent risks with inexact results. In *Exxon Mobile Corporation v. Allapattah Services, Inc.*, ___ U.S. ___, 125 S.Ct. 2611 (2005), the problem was stated as follows:

> As we have repeatedly held, the authoritative statement is the statutory text. Not legislative history or any other extrinsic material. Extrinsic materials have a role in statutory interpretation only to the extent they shed a reliable light on the enacting legislature's understanding of otherwise ambiguous terms. Not all extrinsic materials are reliable sources of insight into legislative understandings, however, and the legislative history in particular is vulnerable to serious criticisms. First, legislative history is itself often murky, ambiguous, and contradictory. Judicial investigation of legislative history has a tendency to become to borrow Judge Leventhal's memorable phrase, an exercise in "'looking over a crowd and picking out your friends.'" Second, judicial reliance on legislative materials like committee reports, which are not themselves subject to the requirements of Article 1, may give unrepresentative committee members . . . or, worse yet, unelected staffers and lobbyists – both the power and the incentive to attempt strategic manipulations of legislative history to secure results they were unable to achieve through the statutory text. *Id.* at 2626.

The Congressional intent to protect the property of a recipient from reimbursement is universal. An inconsistent result would be reached by judicial interpretation of the legislative intent to create an exception not contained in the statute. Should Congress decide to change its mind, it can pass new legislation.

V. The HHS Adjudications Are Not Entitled to Deference

This case does not fall within the parameters of judicial deference to administrative statutory interpretation. Such deference only applies where there is an ambiguity. Under *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 104 S.Ct. 2778 (1984), when Congress had spoken clearly on the subject, there is no place for an administrative agency to instruct the Court on the meaning of the statute. The business of Courts is statutory interpretation. Agency determinations would be helpful in technical regulatory interpretations in areas of which the Courts are not familiar. The reconciliation of three federal statutes goes beyond the expertise of an agency determination and is properly vested with the Courts. The HHS's determinations at issue have a clear conflict with the plain language of the anti-lien statute.

HHS through opinion letters gave three reasons why states could be required to recover funds in excess of those being paid for past medical care of a beneficiary. In noting that third parties should be responsible for reimbursing the government, HHS argues that states are mandated under 42 U.S.C. §1396a(a)(25)(B) to "seek reimbursement for such assistance to the extent of such legal liability." *Washington State Dep't of Social & Health Services*, DAB

No. 1561 at 8, 1996 WL 157123 (Dep't of Health & Human Services February 7, 1996), Pet. App. 47; *California Dep't. of Health Services*, DAB No. 1504 at 10, 1995 WL 66334 (Dep't of Health & Human Services January 5, 1995), Pet. App. 69. As noted by the Eighth Circuit, the phrase "such legal liability," refers to the legal liability of third parties *"to pay for care and services available under the plan."* Payments made for other than past medical expenses are therefore not authorized. Pet. App. 12.

The Eighth Circuit opinion further disagreed with HHS's contention that Medicaid had superior status to the beneficiary in order to receive reimbursement. The Court reasoned Medicaid beneficiaries are only required to assign their rights to third party payments for medical care and therefore, 42 U.S.C. §1396a(a)(25)(H) and §1396k(a)(1)(A) conflict with HHS's opinions. Pet. App. 12-13.

HHS was concerned that plaintiffs would intentionally manipulate settlement figures to artificially lower amounts recovered for past medical expenses. *Washington State Dep't of Social & Health Services*, DAB No. 1561 at 6, 1996 WL 157123 (Dep't of Health & Human Services February 7, 1996), Pet. App. 55; *California Dep't. of Health Services*, DAB No. 1504 at 8-9, 1995 WL 66334 (Dep't of Health & Human Services January 5, 1995), Pet. App. 85-86. The Eighth Circuit opinion correctly pointed out that in such cases, the State could pursue the third party tortfeasor and the Medicaid beneficiary in the event the figures were artificially manipulated because such monies were actually payments for past medical care even though not so denominated. Pet. App. 13-14.

The HHS's determinations relied upon by the State are not of the type entitled to judicial deference with this

Court's holding in *Christensen v. Harris County*, 529 U.S. 576 (2000) where it was stated:

> Here, however, we confront a interpretation contained in an opinion letter, not one arrived at after, for example, a formal adjudication, or notice – and – comment rule marking. Interpretations such as these in opinion letters – like interpretations contained in policy statements, agency manuals and enforcement guidelines, all of which lack the force of law – do not warrant *Chevron*-style deference. *Id.* at 587.

CONCLUSION

Ahlborn respectfully requests that the Court affirm the decision of the Eighth Circuit Court of Appeals. Such an affirmance would leave intact the State's ability to recover its costs directly from third party tortfeasors. In the event Congress desires to carve an exception out of the anti-lien statute, it may amend the Act.

Respectfully submitted,

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FILED
FEB 7 - 2006
OFFICE OF THE CLERK
SUPREME COURT, U.S.

In The

Supreme Court of the United States

ARKANSAS DEPARTMENT OF
HEALTH AND HUMAN SERVICES, et al.,

Petitioners,

v.

HEIDI AHLBORN,

Respondent.

**On Writ Of Certiorari To The
United States Court Of Appeals
For The Eighth Circuit**

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TABLE OF CONTENTS

Page

INTRODUCTION 1

I. Medicaid's TPL Provisions Mandate Full Reimbursement To The Medicaid Program From Third Party Personal Injury Settlement Proceeds 1

II. The Secretary's Adjudications And Interpretations Addressing Medicaid, Which Is A "Complex And Highly Technical Regulatory Program," Are Entitled To Deference And Respectful Consideration 11

CONCLUSION 12

TABLE OF AUTHORITIES

Page

CASES

Arkansas Dep't of Human Servs. v. Estate of Ferrell, 336 Ark. 297 (1999) 7, 8

Wisconsin Dept. of Health & Family Servs. v. Blumer, 534 U.S. 473 (2002) 12

FEDERAL STATUTES

42 U.S.C. § 1396a(a)(25) 4, 5

42 U.S.C. § 1396a(a)(25)(A) 2, 3

42 U.S.C. § 1396a(a)(25)(B) 2, 3, 10

42 U.S.C. § 1396a(a)(25)(H) 2, 3

42 U.S.C. § 1396k 4

42 U.S.C. §1396k(a)(1)(A) 4

42 U.S.C. § 1396k(b) 4, 11

42 U.S.C. § 1396p(a)(1) 5

STATE STATUTES

Ark. Code Ann. § 20-77-30 7

Ark. Code Ann. § 20-77-301(a) 6

Ark. Code Ann. § 20-77-301(b) 6

Ark. Code Ann. § 20-77-307(a) 6, 7

TABLE OF AUTHORITIES – Continued

Page

OTHER AUTHORITIES

S. Rep. No. 99-146 at 279 (1985), *reprinted in* 1986 U.S.C.C.A.N. 42, 312 1

J. Parker, *The Made Whole Doctrine: Unraveling the Enigma Wrapped in the Mystery of Insurance Subrogation*, 70 Mo. L. Rev. 723 (2005) 8

INTRODUCTION

The parties and court of appeals agree that the Arkansas Department of Health and Human Services ("Department") may lawfully place a lien upon some portion of the settlement proceeds at issue; they merely disagree on the size of the portion. A straightforward reading of the third party liability ("TPL") provisions of federal Medicaid law reflect Congress's intent that the Medicaid program recover from third-party settlements the *full* cost of medical assistance provided to the recipient before she may retain any of the settlement proceeds. This interpretation is consistent with Medicaid's anti-lien provision, which protects certain "property" of a recipient from pre-death liens, and likewise squares with Congress's intention that Medicaid remain the "payer of last resort." Nothing in the language of the Medicaid statute nor its legislative history supports Respondent's position that Congress, through the anti-lien provision, limited Medicaid's recovery right to a compromise value of its claim. Moreover, Respondent's position is inconsistent with that of the Secretary of the United States Department of Health and Human Services, which Congress charged with the day-to-day administration of this highly complex administrative scheme.

I. Medicaid's TPL Provisions Mandate Full Reimbursement To The Medicaid Program From Third Party Personal Injury Settlement Proceeds

The strained interpretation of the TPL provisions reached by Respondent Heidi Ahlborn and the court of appeals is contrary to the plain language of those provisions and frustrates Congress's intent that Medicaid remain the "payer of last resort." S. Rep. No. 99-146 at 279

(1985), *reprinted in* 1986 U.S.C.C.A.N. 42, 312. Through these unambiguous provisions, Congress mandated that the Medicaid program receive full reimbursement from proceeds of a third-party settlement before the recipient may retain any of the remaining proceeds. Likewise, a reasonable reading of the provisions does not authorize a recipient to compromise Medicaid's claim for medical costs.

First, 42 U.S.C. § 1396a(a)(25)(A) requires that states determine whether there are third parties who are potentially liable to pay for the care and services that the state Medicaid plan provided to the recipient. Next, 42 U.S.C. § 1396a(a)(25)(B) commands that if such liability is found, that the state must seek reimbursement from such third parties "*to the extent of* such legal liability,"[1] with the only exception being situations in which the amount that the state "can reasonably expect to recover exceeds the cost of such recovery." (emphasis added). Although Congress afforded the states this narrow opportunity to compromise third-party claims,[2] it set forth a general rule that the

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[1] The fact that a tortfeasor and recipient might enter into a compromise settlement does not extinguish the tortfeasor's "legal liability" to Medicaid. Rather, the TPL provisions provide that the third party remains liable to Medicaid to the extent that the program made payments on the recipient's behalf for medical costs triggered by the third party. *See* 42 U.S.C. § 1396a(a)(25)(A), (B), and (H) (2000).

[2] As Amicus United States explained in its brief, "[w]here the State is notified and given an opportunity to participate in settlement negotiations, it may compromise its claim in appropriate circumstances, based on its assessment of the existence or extent of the defendant's liability. But that is a judgment for the State to make, pursuing the objectives of and within the limits imposed by the federal Medicaid program." Br. 13-14. In the present case, however, Ahlborn denied the State this opportunity by unilaterally reaching a settlement with liable third parties and presenting it to the State as a *fait accompli*.

Medicaid program is to be reimbursed by third parties to the maximum extent possible.

Congress's full-reimbursement intent is again reflected in 42 U.S.C. § 1396a(a)(25)(H), which provides:

> That *to the extent that payment has been made under the State plan for medical assistance* in any case where a third party has a legal liability to make payment for such assistance, the State has in effect laws under which, *to the extent that payment has been made under the State plan for medical assistance for health care items or services furnished to an individual*, the State is considered to have acquired the rights of such individual to payment by any other party for such health care items or services.

(emphasis added). In this provision, Congress twice articulated the scope of recovery that state laws must require, making plain Medicaid's right to full reimbursement up "to the extent that payment has been made under the State plan for medical assistance," and "to the extent that payment has been made under the State plan for medical assistance for health care items or services furnished an individual." *Id.*

Congress' language mandating that states effectuate laws under which they are "considered to have acquired the rights of such individuals to payment by any other party for such health care items and services" has but one reasonable interpretation: states acquire a Medicaid recipient's full right to payment from a liable third party "to the extent that payment has been made under the State plan." This construction is fully consistent with 42 U.S.C. § 1396a(a)(25)(A) and (B), which require states to ascertain possible third party liability and to seek

reimbursement "to the extent of such legal liability." Nothing in 42 U.S.C. § 1396a(a)(25) supports Ahlborn's position that she may compromise her entire cause of action and then force the State to accept from such a settlement merely a small portion of what Medicaid paid out for her care.

Congress's intention that Medicaid be the "payer of last resort" is likewise embodied in 42 U.S.C. § 1396k, which conditions Medicaid eligibility upon a recipient's assignment to the State of "any rights" to "payment for medical care from any third party." 42 U.S.C. §1396k(a)(1)(A) (2000). Nothing in the TPL provisions support Ahlborn's reading of "payment for medical care from any third party" as limiting Medicaid's reimbursement right to only that portion of a settlement recovery that the parties consider to be compensation for medical costs. Although a recipient may compromise her own claims in a third-party settlement, as did Ahlborn in the present case, it would frustrate Congress's full Medicaid reimbursement aim to allow a recipient and third party to compromise Medicaid's claim for medical costs.

In furtherance of this goal, Congress also established a payment priority in favor of Medicaid in 42 U.S.C. § 1396k(b), which provides:

> Such part of any amount collected by the State under an assignment made under the provisions of this section shall be retained *as is necessary to reimburse it for medical assistance payments* made on behalf of an individual with respect to whom such assignment was executed (with appropriate reimbursement of the Federal Government to the extent of its participation in the financing of such medical assistance), and the

> remainder of such amount collected shall be paid to such individual.

(emphasis added). As applied to the present case, a straightforward reading of this provision instructs that states must retain from any third-party settlement enough money to fully reimburse Medicaid "for medical assistance payments made on behalf of a [recipient]" before the recipient may retain any of the proceeds. This provision, which creates a payment priority in favor of the Medicaid program, in conjunction with Congress's admonition in 42 U.S.C. § 1396a(a)(25) that states must seek reimbursement "*to the extent of* such legal liability," and "to the extent that payment has been made under the State plan," leave little doubt as to the broad scope of the recipient's assignment to Medicaid.[3]

Disregarding these straightforward statutory mandates, Ahlborn attempts to severely limit Medicaid's recovery rights by invoking Medicaid's "anti-lien" provision. 42 U.S.C. § 1396p(a)(1). Ahlborn's theory is that, notwithstanding that her right to recover her medical expenses from a third party had to be assigned to Medicaid as a condition of receiving benefits, her cause of action is a form of "property" under Arkansas law, and thus the Department was prohibited from pursuing Medicaid's claim for reimbursement from her compromise settlement with a liable third party except for some reduced portion

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[3] The Respondent recognizes that "[n]either the anti-lien statute nor any of the other federal statutes prohibit the state from pursuing its [claim for medical care] independently." Resp. Br. 8. Although this is true, nothing in the Medicaid statute requires the State to litigate its claims directly and opposed to recovering from a third party settlement.

that is considered to be "payment for medical care."[4] The parties agree that the Department has a right to some portion of the third party settlement proceeds; they merely disagree on the size of that portion.

Initially, the parties agree that Ahlborn's cause of action constitutes "property" under Arkansas law, and that this Court has likewise recognized a vested cause of action to be property. Resp. Br. 7. Critically, the State law at issue does not authorize the placement of a lien on Ahlborn's cause of action, but rather expressly prohibits such a lien. *See* Ark. Code Ann. § 20-77-301(a) and (b) (2001) (providing that no action taken by the Department to recover Medicaid costs from a liable third party "shall be a bar to any action upon the claim or cause of action of the recipient . . . [n]or shall any action operate to deny to the recipient the recovery for that portion of any damages not covered hereunder"). In compliance with the federal TPL provisions, however, State law requires as a condition of Medicaid eligibility that a recipient "automatically assign his or her right to any settlement, judgment, or award which may be obtained against any third party . . . to the full extent of any amount which may be paid by Medicaid for the benefit of the applicant."[5] Ark. Code Ann. § 20-77-307(a) (2001).

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[4] Ahborn and the parties with whom she settled did not allocate settlement proceeds between medical and non-medical damages. J.A. 44-45, 49. Because the Department did not learn about the final settlement until after it was completed, J.A. 23, 24, 42, it did not authorize the settlement nor agree to accept a compromise value for its claim. It was only after Ahlborn filed a declaratory judgment action in federal court that the parties stipulated to an allocation *solely* for the purpose of enabling the federal court to rule on the statutory construction issue as a matter of law. J.A. 18-19.

[5] Contrary to Ahlborn's contention that "Arkansas had enacted a law which automatically assigned to DHS all portions of a Medicaid

(Continued on following page)

This assignment is directed to the third-party payment, not Ahlborn's right to pursue a claim for damages. Because Arkansas law authorizes the placement of a lien upon a third-party recovery only to the extent necessary to reimburse Medicaid, as opposed to on a recipient's entire cause of action, it does not run afoul of the anti-lien provision.

Furthermore, Arkansas law places no restriction on a Medicaid recipient's right to pursue a cause of action. Rather, it merely protects Medicaid's federally-mandated right to full reimbursement. As an illustration, Ahlborn chose to pursue a lawsuit as a result of the auto accident at issue. She valued her cause of action at over three million dollars, and had the option to pursue third-party tortfeasors for that entire amount. Rather than go to trial, Ahlborn elected to compromise her claims. Arkansas law in no way restricted her from compromising her own claims, but nothing in the Medicaid Act, including the anti-lien provision, authorized her to compromise any portion of Medicaid's claim for full reimbursement.

Disregarding the mandatory and straightforward language of the TPL provisions, Amicus Association of American Trial Lawyers ("ATLA") argues that Congress

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recipient's recovery," Resp. Br. 3, the assignment is limited to the total amount paid by Medicaid on behalf of the recipient. Ark. Code Ann. § 20-77-307(a) (2001). Additionally, due to the placement of the assignment provision in Title 20, Chapter 77, Subchapter 3 of Arkansas Code Annotated entitled "Third-Party Liability," *see* Ark. Code Ann. § 20-77-30 *et seq.*, Ahlborn's concern that the assignment provision could be read to apply to property received "from a wealthy aunt" is misplaced. Resp. Br. 4-5. *See also Arkansas Dep't of Human Servs. v. Estate of Ferrell*, 336 Ark. 297, 303 (1999) ("Subchapter 3 [of Title 20, Chapter 77], titled 'Third-Party Liability,' addresses the means by which [the Department] can recover Medicaid expenditures when a third party is at fault in causing injuries to the Medicaid recipient").

intended that a Medicaid recipient be allowed "to retain an equitable portion of any recovery" received in a third-party settlement. Br. 7. In support of this argument, ATLA refers to the "made whole" doctrine, a common law equitable subrogation doctrine providing that "a health insurer may not obtain reimbursement for medical payments from a third-party tortfeasor until the injured plaintiff has been fully compensated for his damages." Br. 7 n. 5. Such an equitable subrogation doctrine has no place in the present analysis, however, because the federal TPL provisions plainly mandate full Medicaid reimbursement. Additionally, the Medicaid program is not a "health insurer." Finding the made whole doctrine inapplicable to the State Medicaid program in *Arkansas Dep't of Human Services v. Estate of Ferrell*, the Arkansas Supreme Court explained:

> [The Department] is not a private insurance company. It is a state agency statutorily charged with the responsibility to administer the federal Medicaid program. Federal law requires states which choose to participate in the Medicaid program to "take all reasonable measures to ascertain the legal liability of third parties" . . . It also requires the state to seek recovery of reimbursement from the third party to the limit of their liability after Medicaid claims payment.

984 S.W.2d 807, 808-09 (Ark. 1999) (*citing* 42 U.S.C. § 1396a(a)(25) and 42 C.F.R. §§ 433, 138, 139).

Furthermore, because the made whole doctrine's purpose is to "limit[] the ability of an *insurer* to exercise its right of subrogation until the insured has been fully compensated or made whole," J. Parker, *The Made Whole Doctrine: Unraveling the Enigma Wrapped in the Mystery of Insurance Subrogation*, 70 Mo. L. Rev. 723, 737 (2005)

(emphasis added), it would not apply to health care providers who provide services to an uninsured patient. Thus, assuming *arguendo,* that Ahlborn had not applied for Medicaid assistance but rather accumulated $320,000[6] in medical bills, her medical providers (e.g., hospital, doctors) would have a lien on her entire $550,000 settlement recovery that could not be reduced through the "made whole" doctrine. As the Petitioners discussed in their Brief, Congress surely did not intend that Medicaid receive less favorable treatment with regard to reimbursement than a private medical provider. Pet. Br. 46.

Advocating for a "rule of equitable apportionment," ATLA correctly recognizes that it would be "inappropriate . . . for this Court to establish specific procedures for state court judicial proceedings to allocate settlement proceeds." Br. 21. It thus proposes that "state courts and legislators" perform the task. *Id.* Aside from the fact that such a rule would run afoul of the federal TPL provisions and frustrate Congress's full reimbursement goal, it would also jeopardize the uniform application of federal law.

ATLA posits that a rule of equitable apportionment would increase Medicaid's third party liability reimbursements. Br. 19. First and foremost, as a result of Congress's full reimbursement mandate, federal law would not condone such a rule. Regardless, the proposition is mere

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[6] The Department received bills from Ahlborn's health care providers for approximately $320,000 for accident-related expenses. J.A. 22, 42. The Medicaid program's ultimate financial obligation to the providers, however, was $215,645.30, the payment of which fully extinguished Ahlborn's financial obligation. *Id.* Thus, by virtue of her participation in the Medicaid program, Ahlborn's actual medical costs were reduced by over $100,000.

speculation. ATLA argues that Medicaid recovered "only" 1.6 *billion* dollars in 2004 from liable third-party payments, which constitutes but a small percentage of the amount for which third parties allegedly were liable. Br. 17 (emphasis added). However, it offered no evidence as to why full recovery was not made, and certainly there are a myriad of reasons. For example, a motorist who causes an auto accident that triggers tremendous Medicaid expenditures might be judgment proof but for a $25,000 liability insurance policy.

ATLA also argues that the full reimbursement rule advanced by the Department "would discourage settlements and impede the efficient resolution of legal disputes." Br. 9. Undoubtedly, settlements are a major component of our civil system of justice. ATLA's argument is flawed from both a legal and practical perspective, however, as it fails to recognize: (1) Congress's mandate that states pursue liable third parties "to the extent of [their] legal liability," and (2) that Congress afforded states only a narrow opportunity to compromise third-party claims. 42 U.S.C. § 1396a(a)(25)(B) (2000). Consequently, application of the appeals court's rule that states are entitled to recover only that portion of a settlement considered to be compensation for medical costs would not end the states' statutory duty to continue to seek full recovery, and thus would not end the litigation. And third parties would likely not be amenable to settling a case with a recipient unless Medicaid's claim was fully satisfied, thus ending the entire dispute. In any event, although the states' opportunity to settle cases is a narrow one, if it is notified and given an opportunity to participate in settlement negotiations, it may compromise its claim in appropriate circumstances.

II. The Secretary's Adjudications And Interpretations Addressing Medicaid, Which Is A "Complex And Highly Technical Regulatory Program," Are Entitled To Deference And Respectful Consideration

In discussing the degree of deference due to the Secretary, Ahlborn erroneously refers to formal adjudications of the Departmental Appeals Board of the United States Department of Health and Human Services as "opinion letters." Resp. Br. 17. The parties appear to agree that informal policy interpretations issued by an agency charged with the administration of a statute, such as those contained in an "opinion letter," are entitled to less than *Chevron* deference. *See* Resp. Br. 18-19, Pet. Br. 44-45. Unlike an informal policy interpretation, however, Departmental Appeals Board decisions that are reached through formal adjudication are entitled to *Chevron* deference. *See* Pet. Br. 37-41.

Amicus ATLA argues that no degree of deference is due to the Secretary's "formal" or "informal" interpretations. Br. 8-9 n. 6. First, they argue that the "administrative rulings are flatly inconsistent with the text of the act, which nowhere grants priority to a state Medicaid agency's claim for reimbursement." *Id.* This argument ignores Congress's full reimbursement mandate set forth throughout the TPL provisions, as well as the requirement of 42 U.S.C. § 1396k(b) that the state shall retain any amount collected under the assignment provision "as is necessary to reimburse it for medical assistance payments made on behalf of [the recipient]," with only the remainder being paid to the recipient.

Second, ATLA argues that the present issue "involve[s] only a straightforward issue of statutory construction." Br.

8-9 n. 6. The Department agrees that the language of the Medicaid statutes is "straightforward" and unambiguous, but disagrees with Ahlborn and ATLA's reading. *Id.* To the extent that an ambiguity exists, however, courts should defer (or give "respectful consideration") to the agency that is responsible for the day-to-day administration of Medicaid's highly complex administrative scheme. Finally, ATLA's argument that the Secretary's interpretation "should be disregarded as entirely self-serving" is unfounded, as it fails to recognize Congress's "extremely broad [delegation of] regulatory authority to the Secretary in the Medicaid area," *Wisconsin Dept. of Health & Family Servs. v. Blumer,* 534 U.S. 473, 497 n. 13 (2002) (citations omitted).

CONCLUSION

For the foregoing reasons and those stated in Petitioners' opening brief, the decision of the court of appeals should be reversed.

Respectfully submitted,

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Supreme Court, U.S.
FILED
NOV 23 2005
OFFICE OF THE CLERK

No. 04-1506

In the Supreme Court of the United States

ARKANSAS DEPARTMENT OF HEALTH AND HUMAN SERVICES, ET AL., PETITIONERS

v.

HEIDI AHLBORN

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE SUPPORTING PETITIONERS

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QUESTION PRESENTED

The federal Medicaid program, 42 U.S.C. 1396 *et seq.*, requires participating States to "take all reasonable measures to ascertain the legal liability of third parties" for medical expenses paid by Medicaid and to "seek reimbursement for such [medical] assistance to the extent of such legal liability." 42 U.S.C. 1396a(a)(25)(A) and (B). To that end, Medicaid beneficiaries must "assign the State any rights * * * to payment for medical care from any third party." 42 U.S.C. 1396k(a)(1)(A). Federal law also prohibits States from imposing any lien "against the property of any individual prior to his death on account of medical assistance paid." 42 U.S.C. 1396p(a)(1). The question presented is:

Whether, when a Medicaid beneficiary receives a lump-sum settlement from a third party who is legally liable for the costs of her medical care, Medicaid's claim to full reimbursement is properly accorded priority in the distribution of the settlement proceeds.

TABLE OF CONTENTS

Page

Interest of the United States 1
Statement 1
Summary of argument 7
Argument:
The Medicaid statute requires that Medicaid expenses be reimbursed first and in full out of a beneficiary's lump-sum settlement, to the extent of the third party's liability for such medical expenses 9
A. The text and purpose of Medicaid's third-party liability provisions require full reimbursement 10
1. Medicaid is the payer of last resort 10
2. The text of the third-party liability provisions requires full compensation of Medicaid's claim from settlements 12
3. The Medicaid statute does not require the State to litigate its own claims directly 15
B. Full recovery of the State's medical expenses from a settlement is consistent with Medicaid's anti-lien provision 17
1. The lien does not attach to the beneficiary's property 18
2. Respondent has no federally recognized property right 19
3. The anti-lien provision protects, but does not independently define, property rights 24
C. The Secretary's harmonization of Medicaid's provisions merits deference 25
Conclusion 30
Appendix 1a

TABLE OF AUTHORITIES

Cases: Page

Arkansas Dep't of Human Servs. v. *Estate of Ferrel*, 984 S.W. 2d 807 (Ark. 1999) 18, 19, 20, 21

Arizona Health Care Cost Containment Sys. v. *Bentley*, 928 P.2d 653 (Ariz. Ct. App. 1996), review denied (Dec. 17, 1996) 10

Auer v. *Robbins*, 519 U.S. 452 (1997) 26

Barnhart v. *Walton*, 535 U.S. 212 (2002) 26, 27

California Dep't of Health Servs., In re, Dec. No. 1504 (HHS Jan. 5, 1995) 23, 27, 28, 29, 30

Calvanese v. *Calvanese*, 710 N.E.2d 1079 (N.Y.), cert. denied, 528 U.S. 928 (1999) 10, 29

Commissioner v. *Schleier*, 515 U.S. 323 (1995) 17

Copeland v. *Toyota Motor Sales U.S.A., Inc.*, 136 F.3d 1249 (10th Cir. 1998) 10

Cricchio v. *Pennisi*, 683 N.E.2d 301 (N.Y. Ct. App. 1997) 19

Dames & Moore v. *Regan*, 453 U.S. 654 (1981) ... 19, 20

Delaney v. *Commissioner*, 99 F.3d 20 (1st Cir. 1996) 17

Dotson v. *United States*, 87 F.3d 682 (5th Cir. 1996) 17

Drye v. *United States*, 528 U.S. 49 (1999) 19, 20

Gould v. *Day*, 94 U.S. 405 (1876) 18

Grayam v. *Department of Health & Human Res.*, 498 S.E.2d 12 (W. Va. 1997) 10

Great-West Life & Annuity Ins. Co. v. *Knudson*, 534 U.S. 204 (2002) 21

Cases—Continued: Page

Grey Bear v. *North Dakota Dep't of Human Servs.*, 651 N.W.2d 611 (N.D. 2002), cert. denied, 539 U.S. 960 (2003) 10

Harris Trust & Sav. Bank v. *Salomon Smith Barney, Inc.*, 530 U.S. 238 (2000) 21

Houghton v. *Department of Health*, 57 P.3d 1067 (Utah 2002), cert. denied, 538 U.S. 945 (2003) .. 10, 19

Kietur, In re, 752 A.2d 799 (N.J. Super. Ct. App. 2000) 10

King v. *St. Vincent's Hosp.*, 502 U.S. 215 (1991) 26

Martin v. *City of Rochester*, 642 N.W.2d 1 (Minn. 2002), cert. denied, 539 U.S. 957 (2003) 10

Memorial Hosp. v. *Maricopa County*, 415 U.S. 250 (1974) 10

National Cable & Telecomms. Ass'n v. *Brand X Internet Servs.*, 125 S. Ct. 2688 (2005) 21

O'Brien v. *Skinner*, 414 U.S. 524 (1974) 21

Payne v. *State*, 486 S.E.2d 469 (N.C. Ct. App.), review denied, 493 S.E.2d 656 (N.C. 1997) 10

Richards v. *Georgia Dep't of Cmty. Health*, 604 S.E.2d 815 (Ga. 2004) 10, 19, 30

Roberts v. *Total Health Care, Inc.*, 709 A.2d 142 (Md. Ct. App. 1998) 10

Rose v. *Rose*, 481 U.S. 619 (1987) 22

S.S. v. *State*, 972 P.2d 439 (Utah 1998) 10

Schaffer v. *Weast*, No. 04-698 (Nov. 14, 2005) 24

Schweiker v. *Gray Panthers*, 453 U.S. 34 (1981) 11, 26, 28

Sullivan v. *County of Suffolk*, 174 F.3d 282 (2d Cir.), cert. denied, 528 U.S. 950 (1999) 10

Cases—Continued: Page

United States v. *Craft*, 535 U.S. 274 (2002) 19, 20
United States v. *Lorenzetti*, 467 U.S. 167 (1984) 14
Washington State Dep't of Social & Health Servs., In re, Dec. No. 1561 (HHS Feb. 7, 1996) 23, 27, 28, 29
Washington State Dep't of Social & Health Servs. v. *Guardianship Estate of Keffeler*, 537 U.S. 371 (2003) 26
West Va. Univ. Hosps., Inc. v. *Casey*, 499 U.S. 83 (1991) 26
Wilson v. *State*, 10 P.3d 1061 (Wash. 2000), cert. denied, 532 U.S. 1020 (2001) 10, 16, 19
Wisconsin Dep't of Health & Family Servs. v. *Blumer*, 534 U.S. 473 (2002) 2, 27
Zinman v. *Shalala*, 67 F.3d 841 (9th Cir. 1995) 4, 10, 23

Statutes and regulations:

Social Security Act, Title XIX, 42 U.S.C. 1396 *et seq.* 1
42 U.S.C. 1396 11
42 U.S.C. 1396a (2000 & Supp. II 2002) 2
42 U.S.C. 1396a(a)(10) 11
42 U.S.C. 1396a(a)(25)(A) 2, 16, 1a
42 U.S.C. 1396a(a)(25)(A)(i) 3
42 U.S.C. 1396a(a)(25)(A)(ii) 2
42 U.S.C. 1396a(a)(25)(B) ..... *passim*, 2a
42 U.S.C. 1396a(a)(25)(H) 3, 14, 4a
42 U.S.C. 1396a(a)(45) 3, 4a
42 U.S.C. 1396d(b) 1

Statutes and regulations—Continued: Page

42 U.S.C. 1396k(a)(1)(A) ..... *passim*, 5a
42 U.S.C. 1396k(a)(1)(C) ..... *passim*, 6a
42 U.S.C. 1396k(b) ..... *passim*, 6a
42 U.S.C. 1396p(a)(1) 4, 17, 18, 7a
42 U.S.C. 1396p(a)(1)(A) 4, 21, 7a
26 U.S.C. 104(a)(2) 17
42 U.S.C. 1302 ..... 1, 2
42 U.S.C. 1395y(b)(2)(B)(ii) 4
Ark. Code Ann. (Michie 1991):
§ 20-77-302 ..... 19, 23
§ 20-77-302(a) 5
§ 20-77-302(b) 5, 13, 14, 15
§ 20-77-303(b) 5
§ 20-77-304(a) 5
§ 20-77-304(b) 5, 15
§ 20-77-305 23
§ 20-77-305(a) 5, 15
§ 20-77-307(a) 4
§ 20-77-307(b) 4
§ 20-77-307(c) 4, 18
42 C.F.R.:
Section 411.24(c) 4
Section 430.10 2
Section 430.42(b) 27
Sections 433.135 *et seq.* 4
Section 433.136 ..... 2, 9a
Section 433.138 ..... 2, 9a

Regulations—Continued: Page

Section 433.147(b)(4) 3, 13, 21, 23, 21a

Section 433.154 ..... 3, 28, 22a

45 C.F.R. 16.1-16.23 27

App. A 27

Miscellaneous:

George T. Bogert:

Trusts (6th ed. 1987) 21

Trusts and Trustees (2d ed. rev. 1978 & Supp. 2004) 21

Centers for Medicare & Medicaid Servs., Dep't of Health & Human Servs., *State Medicaid Manual* (last modified Sept. 16, 2004) <www.cms.hhs.gov/manuals/45_smm/sm_03_3_toc.asp> 3

Centers for Medicare & Medicaid Servs., *Medicare Intermediary Manual*, Pt. 3, Ch. V (Dec. 1994) 22

52 Fed. Reg. 5971 (1987) 2

66 Fed. Reg. 35,437 (200[illegible] 2

Health Care Fin. Admin., Dep't of Health & Human Servs., *Dallas Regional Medical Servs. Letter No. 88-23* (June 1, 1998) 23

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Miscellaneous—Continued: Page

S. Rep. No. 146, 99th Cong., 1st Sess. (1985) 11
S. Rep. No. 744, 90th Cong., 1st Sess. (1967) 11

In the Supreme Court of the United States

No. 04-1506

ARKANSAS DEPARTMENT OF HEALTH AND HUMAN SERVICES, ET AL., PETITIONERS

v.

HEIDI AHLBORN

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE SUPPORTING PETITIONERS

INTEREST OF THE UNITED STATES

This case concerns the third-party liability provisions of the federal Medicaid Act, which represent a significant source of compensation for that program at both the federal and state levels. In 2004, approximately $1.6 billion in third party liability payments were recovered nationwide. Congress has vested the Secretary of Health and Human Services with broad authority to administer the Medicaid program. 42 U.S.C. 1302. The question presented directly implicates the Secretary's interpretation and implementation of the Medicaid statute.

STATEMENT

1. a. Medicaid, which Congress enacted as Title XIX of the Social Security Act, 42 U.S.C. 1396 *et seq.*, is a cooperative federal-state program under which the federal government provides funding to States to provide medical assistance to indigent individuals. Under the program, the federal government pays between 50% and 83% of the cost of patient care incurred by a State, as determined by a formula keyed to each State's *per capita* income. See 42 U.S.C. 1396d(b). In Arkansas, the federal government generally has paid approximately 74% of each patient's care. States that participate in the Medicaid program must sub-

mit to the Secretary of Health and Human Services (Secretary) a plan for medical assistance that conforms to the requirements of the Medicaid statute. See 42 U.S.C. 1396a (2000 & Supp. II 2002); 42 C.F.R. 430.10. All 50 States participate in the Medicaid program.

Congress has charged the Secretary with administering the federal Medicaid program, including reviewing and approving State plans and operations, and has vested the Secretary with "extremely broad regulatory authority" to implement the requirements of the Medicaid Act. *Wisconsin Dep't of Health & Family Servs.* v. *Blumer*, 534 U.S. 473, 496 n.13 (2002); see 42 U.S.C. 1302. The Secretary exercises his authority through the Centers for Medicare and Medicaid Services (formerly the Health Care Financing Administration). See 66 Fed. Reg. 35,437 (2001).

b. At times, an individual's need for Medicaid arises from circumstances, such as injuries incurred in an automobile accident, that render third parties liable for the costs of the beneficiary's medical care.[1] Potentially responsible third parties include tortfeasors, insurance companies, employee health benefit plans, and non-custodial parents. See 42 C.F.R. 433.136, 433.138. In order to preserve Medicaid's role as the payer of last resort and to maximize the amount of assistance available for all qualifying individuals, the Medicaid statute requires participating States to "take all reasonable measures to ascertain the legal liability of third parties * * * to pay for care and services" provided by Medicaid. 42 U.S.C. 1396a(a)(25)(A). Each State's plan also must specify how it will pursue third-party liability claims. 42 U.S.C. 1396a(a)(25)(A)(ii). That plan must include provisions for the collection, any time a beneficiary's eligibility is established or redetermined, of "sufficient in-

[1] "[E]xperience indicates that due to the severity of motor vehicle accident related injuries, extended medical care is usually required which results in substantial Medicaid program expenditures." 52 Fed. Reg. 5971 (1987).

formation" "to enable the State to pursue claims against such third parties." 42 U.S.C. 1396a(a)(25)(A)(i).

In addition, the State must enact "laws under which * * * the State is considered to have acquired the rights of such individual to payment by any other party for such health care items or services." 42 U.S.C. 1396a(a)(25)(H). Each State's Medicaid plan also must require, as "a condition of eligibility," that recipients "assign the State any rights * * * to payment for medical care from any third party." 42 U.S.C. 1396k(a)(1)(A); see 42 U.S.C. 1396a(a)(45). States likewise must require Medicaid beneficiaries to "cooperate with the State in identifying, and providing information to assist the State in pursuing, any third party who may be liable to pay for care and services available under the plan." 42 U.S.C. 1396k(a)(1)(C). As an "essential[]" part of such cooperation, States can require beneficiaries to "[p]ay to the agency any support or medical care funds received that are covered by the assignment of rights." 42 C.F.R. 433.147(b)(4).

Once potential third-party liability for medical care and services is identified, the State must "seek reimbursement for [its] assistance to the extent of such legal liability." 42 U.S.C. 1396a(a)(25)(B). With respect to any money collected by the State following an assignment, the Medicaid statute accords priority to the State's claim for reimbursement by directing the State to "retain[]" "[s]uch part of any amount collected * * * as is necessary to reimburse it for medical assistance payments made." 42 U.S.C. 1396k(b); see 42 C.F.R. 433.154. The State, in turn, must reimburse the federal government for its share of the payments. *Ibid.* Only then will "the remainder of such amount collected" be paid to the beneficiary. *Ibid.*[2] The Secretary has promul-

[2] The Secretary allows for deduction of the costs of obtaining the award, including attorneys' fees, before reimbursement of the Medicaid program. Centers for Medicare & Medicaid Servs., Dep't of Health & Human Servs.,

gated regulations that implement Medicaid's third-party liability provisions. See 42 C.F.R. 433.135 *et seq.*[3]

c. The Medicaid statute separately provides that "[n]o lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan." 42 U.S.C. 1396p(a)(1). An exception is made for liens imposed "pursuant to the judgment of a court on account of benefits incorrectly paid on behalf of such individual." 42 U.S.C. 1396p(a)(1)(A).

2. As a participant in the federal Medicaid program, Arkansas provides by law that, "[a]s a condition of eligibility, every Medicaid applicant shall automatically assign his or her right to any settlement, judgment, or award which may be obtained against any third party to the Arkansas Department of Health and Human Services to the full extent of any amount which may be paid by Medicaid for the benefit of the applicant." Ark. Code Ann. § 20-77-307(a) (Michie 1991). "The application for Medicaid benefits shall, in itself, constitute an assignment by operation of law." *Id.* § 20-77-307(b). State law further provides that the "assignment shall be considered a statutory lien on any settlement, judgment, or award received by the recipient from a third party." *Id.* § 20-77-307(c).

If a Medicaid beneficiary brings suit against a "third party who may be liable for [her] injury, disease, disability, or death," "any settlement, judgment, or award obtained is subject to the [State's] claim for reimbursement of the benefits provided to the recipient under the medical assistance

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State Medicaid Manual § 3907 (last modified Sept. 16, 2004), <www.cms.hhs.gov/manuals/45_smm/ sm_03_3_toc. asp>.

[3] Under Medicare, the government likewise must be reimbursed in full, to the extent of the third party's liability for medical damages, before tort settlement proceeds may be used for other purposes. See 42 U.S.C. 1395y(b)(2)(B)(ii); 42 C.F.R. 411.24(c); see generally *Zinman* v. *Shalala*, 67 F.3d 841, 845 (9th Cir. 1995).

program." Ark. Code Ann. § 20-77-302(a). That same law accords the State's claim for Medicaid reimbursement priority in the distribution of any settlement, judgment, or award, irrespective of whether the recipient alone brought the action or whether the State also participated. *Id.* §§ 20-77-302(b), 20-77-303(b). In addition, Medicaid beneficiaries must notify the State of the institution or settlement of any claims against third parties who are liable for medical expenses. *Id.* § 20-77-304(a) and (b). "No judgment, award, or settlement in any action or claim by a medical assistance recipient to recover damages for injuries, disease, or disability" in which the State has an interest can be "satisfied without first giving the [State] notice and a reasonable opportunity to establish its interest." *Id.* § 20-77-305(a).

3. After sustaining permanently disabling injuries in a car accident, respondent applied for and received more than $215,000 in medical assistance from the Arkansas Medicaid program. Those benefits have "fully relieved her debt to health care providers." Pet. App. 2; J.A. 11. In applying for benefits, respondent assigned to the State her "right to any settlement, judgment, or award" that she might receive from third parties up "to the full extent of any amount which may be paid by Medicaid" on her behalf. Pet. App. 2.

Respondent subsequently filed a state-court suit against her insurance company and other third parties that she alleged were legally liable for her injuries. Pet. App. 2. She asserted more than $3 million in damages for her medical care, pain and suffering, and lost earning capacity. *Id.* at 2, 17. The State intervened in the suit. J.A. 24. Respondent, however, settled the litigation for $550,000, without any advance notice to the State. Pet. App. 2. The settlement was paid as a lump-sum amount that was not allocated among the various damages claims. *Ibid.* Those sums purported to constitute full and complete settlement of all

claims of any nature, whether past or future, arising out of respondent's injuries. J.A. 4-5; see J.A. 12, 23-24. The State then asserted a lien against the settlement proceeds in the amount of the medical benefits that it had provided to respondent. Pet. App. 2.

4. Respondent filed suit in federal district court against petitioners, the Arkansas Department of Human Services and a number of its officials (collectively "Arkansas"), seeking a declaratory judgment that the Medicaid statute forbids Arkansas from recovering more than the percentage of the settlement that respondent herself attributes to medical expenses. Pet. App. 3. The parties stipulated that respondent would have claimed $3,040,708.12 in total damages had the state court litigation gone to trial. *Id.* at 2. Because the $550,000 settlement was deemed to represent one-sixth of the total recovery she sought from third parties—it actually represents a recovery of just over 18%—respondent contended that Arkansas could only recover 16.5% of its medical damages claim, which amounts to $35,581.47. *Id.* at 3; J.A. 18.

The district court granted summary judgment for Arkansas. Pet. App. 16-31. Considering the statute as a whole and Medicaid's intended role as the "payer of last resort," *id.* at 30 & n.6, and deferring to the Secretary's interpretation of the proper operation of the third-party liability and lien provisions, *id.* at 28, 30, the court concluded that Arkansas was entitled to full reimbursement of its medical expenses, *id.* at 30. In the district court's view, respondent's prior assignment of her right to recover medical damages from liable third parties eliminated her property interest in that money, which made the Medicaid statute's anti-lien provision "drop[] out of the analysis." *Id.* at 26. The district court observed that respondent's contrary approach would promote "manipulation of tort awards by recipients who seek to prevent the public from being reim-

bursed for the funds it has advanced for their medical care," and who thus have "no interest in placing an appropriate value on that component of recovery." *Id.* at 31.

5. The court of appeals reversed. Pet. App. 1-15. The court held that Medicaid's anti-lien provision limits the State to recovering only that portion of the lump-sum settlement that is designated, after the fact, to be compensation for medical care. *Id.* at 10. Finding that Medicaid beneficiaries have a property interest in their "right to a settlement that may be received from a third party," *id.* at 6, the court concluded that the anti-lien provision precluded Arkansas from recovering anything more than the amount respondent had designated as medical damages. *Ibid.* The court rejected the Secretary's view that States must recover more than just a compromised payment for medical costs as "inconsistent with the plain language of the statute." *Id.* at 11. The court noted the Secretary's and the State's concern about the manipulation of settlement amounts, but reasoned that a State could address that problem by suing the third-party tortfeasor directly, *id.* at 13, or by seeking to "recharacterize" settlement amounts ostensibly for other purpose as payments for medical expenses, *id.* at 14. Here, however, the court held that Arkansas's recovery was limited to $35,581.47, while respondent was free to retain $180,063.83 that otherwise would have been used to reimburse Medicaid expenses. *Id.* at 2, 14-15.

SUMMARY OF ARGUMENT

A. Medicaid is the payer of last resort for medical expenses of the indigent. To preserve that status, the Medicaid Act requires participating States and beneficiaries acting in cooperation with them to seek to recover from responsible third parties the full amount of medical assistance rendered. As the Medicaid statute and Arkansas law require, respondent assigned to the State her right to recover medical damages from third parties to the full extent

of those parties' legal liability for Medicaid's expenses. By pressing its entitlement to full payment of its claim for medical damages out of the settlement proceeds, Arkansas seeks merely to vindicate its own assigned right; it does not impermissibly encroach upon any distinct property rights held by the beneficiary.

The fundamental flaw in the court of appeals' holding that States may recover only a portion of a post hoc allocation of settlement proceeds is that it mistakenly equates a *compromised* payment of medical damages with the *full extent* of the paying party's legal liability for medical damages. The text and purposes of the Medicaid Act demand that the beneficiary cooperate with the State in collecting the latter, rather than unilaterally resolving the third parties' liability and attempting to force the State, after the fact, to accept only a fraction of its claim, while keeping the balance for herself. The rule that the Medicaid claim be paid first and in full preserves Medicaid as the payer of last resort, gives full effect to the State's assigned right to medical damages and priority in their compensation, compels beneficiaries to adhere to their voluntarily assumed duty of cooperation with the State, and prevents unjustified inequities in the administration of the Medicaid program.

That rule also accords with common sense. Respondent's suit against the responsible third parties resolved their liability for her medical damages. Because the State's and federal government's claims were not—could not—have been unilaterally compromised by respondent, federal law reasonably treats the settlement amount as encompassing the full amount of the Medicaid claim.

B. The requirement of full payment does not implicate Medicaid's anti-lien provision. That provision protects property that rightfully belongs to the Medicaid beneficiary, not property that federal law requires to be assigned to the State as a condition of the beneficiary's receipt of

Medicaid benefits in the first instance. To the extent that the portion of the settlement proceeds dedicated to compensation of Arkansas' medical damages claim temporarily passed into respondent's hands, she held it in constructive trust for the State. To hold otherwise would invite the arbitrary truncation, if not outright manipulation, of settlement awards to deprive the taxpayers' of their rightful claim to reimbursement for Medicaid benefits. The Secretary of Health and Human Services has reasonably interpreted the Medicaid statute not to require that result, and that interpretation is entitled to deference. The court of appeals, for its part, offered no reason why respondent, who received benefits conditioned upon assigning her full right to payments for medical expenses and cooperating with the State in maximizing that recovery, should obtain a $180,000 windfall based on nothing more than her unilateral compromise of the State's claim to reimbursement, without fair notice to the State and in contravention of her duty of cooperation.

ARGUMENT

THE MEDICAID STATUTE REQUIRES THAT MEDICAID EXPENSES BE REIMBURSED FIRST AND IN FULL OUT OF A BENEFICIARY'S LUMP-SUM SETTLEMENT, TO THE EXTENT OF THE THIRD PARTY'S LIABILITY FOR SUCH MEDICAL EXPENSES

The problem at hand—which is a common one—arises when a Medicaid beneficiary unilaterally obtains a lump-sum settlement from responsible third parties that resolves their liability for damages, medical and otherwise, without affording the State an opportunity to protect its own interests or providing any objective determination of the actual extent of the defendants' liability for medical damages. That problem can be avoided by the simple expedient of the beneficiary honoring her duty of cooperation and involving the State in the settlement process. In the Secretary's

view, the text and purposes of the Medicaid Act require that, in the event of unilateral action that excludes the State, the Medicaid claim be paid first and in full. Any other approach would run afoul of statutory text and purposes, would reward beneficiaries' circumvention of their statutory duties of assignment and cooperation, and would make the Medicaid program a source of financial windfalls, rather than a payer of last resort.[4]

A. The Text And Purpose Of Medicaid's Third-Party Liability Provisions Require Full Reimbursement

1. Medicaid is the payer of last resort

Medicaid is "the primary federal program for providing medical care to indigents at public expense." *Memorial Hosp.* v. *Maricopa County*, 415 U.S. 250, 262 n.19 (1974). Unlike Medicare, Medicaid does not function as an insur-

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[4] Almost every court to decide the question has agreed with the Secretary's position. See *Sullivan* v. *County of Suffolk*, 174 F.3d 282, 286 & n.5 (2d Cir.), cert. denied, 528 U.S. 950 (1999); *Copeland* v. *Toyota Motor Sales U.S.A., Inc.*, 136 F.3d 1249, 1258 (10th Cir. 1998); *Richards* v. *Georgia Dep't of Cmty. Health*, 604 S.E.2d 815 (Ga. 2004); *Houghton* v. *Department of Health*, 57 P.3d 1067, 1069 (Utah 2002), cert. denied, 538 U.S. 945 (2003); *Grey Bear* v. *North Dakota Dep't of Human Servs.*, 651 N.W.2d 611, 617-618 (N.D. 2002), cert. denied 539 U.S. 960 (2003); *Wilson* v. *State*, 10 P.3d 1061, 1066 (Wash. 2000), cert. denied, 532 U.S. 1020 (2001); *Calvanese* v. *Calvanese*, 710 N.E.2d 1079, 1081-1082 (N.Y.), cert. denied, 528 U.S. 928 (1999); *S.S.* v. *State*, 972 P.2d 439, 442-443 (Utah 1998); *Roberts* v. *Total Health Care, Inc.*, 709 A.2d 142, 148-149 (Md. Ct. App. 1998); *Grayam* v. *Department of Health & Human Res.*, 498 S.E.2d 12, 20-21 (W. Va. 1997); *In re Kietur*, 752 A.2d 799 (N.J. Super. Ct. App. 2000); *Payne* v. *State*, 486 S.E.2d 469, 471 (N.C. Ct. App. 1997), review denied, 493 S.E.2d 656 (N.C. 1997); cf. *Zinman*, 67 F.3d at 844-845 (same, under Medicare program); but see *Arizona Health Care Cost Containment Sys.* v. *Bentley*, 928 P.2d 653, 656 (Ariz. Ct. App. 1996) (" 'Medical benefits' does not include tort settlement proceeds."), review denied (Dec. 17, 1996). Contra *Martin* v. *City of Rochester*, 642 N.W.2d 1, 13 (Minn. 2002) (anti-lien provision violated where state law assigned a cause of action, rather than a right to payment, and where state property law attached independent property rights to each component of damages), cert. denied, 539 U.S. 957 (2003).

ance plan. It is a needs-based entitlement program for the poor, "whose income and resources are insufficient to meet the costs of necessary medical services." 42 U.S.C. 1396; see *Schweiker* v. *Gray Panthers*, 453 U.S. 34, 36 (1981). "Medicaid is intended to be the payer of last resort" for needy individuals, S. Rep. No. 146, 99th Cong., 1st Sess. 312 (1985). All "other available resources must be used before Medicaid pays for the care of an individual enrolled in the Medicaid program." *Ibid.*

It is not uncommon for Medicaid to provide benefits to individuals who have extremely limited resources available to pay for medical care, see 42 U.S.C. 1396a(a)(10), but for whom third parties (such as tortfeasors, insurance companies, or non-custodial parents) may be liable for all or a portion of the medical expenses incurred. S. Rep. No. 744, 90th Cong., 1st Sess. 184 (1967).[5] Medicaid often pays first in circumstances like respondent's unfortunate sudden and serious accident because the applicant lacks the funds at hand to pay for large medical bills. Medicaid steps in on short notice, affording the beneficiary needed medical care, respite from medical debts, and medical security. But Medicaid's status as the payer of last resort can only be preserved in those circumstances if Medicaid's third-party liability provisions are stringently enforced. Accordingly, when those same beneficiaries later recover payments from third parties, the Medicaid Act requires them to reimburse the Medicaid program to the extent of the third parties' liability for medical damages, before retaining funds for themselves. Otherwise, Medicaid becomes a program of short-term financial expedience that enables long-term financial windfalls, rather than a payer of last resort for the truly indigent.

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[5] The Secretary has advised that approximately 17% of all Medicaid beneficiaries have some form of third-party coverage for their medical expenses.

2. *The text of the third-party liability provisions requires full compensation of Medicaid's claim from settlements*

By its plain terms, the Medicaid statute requires States to seek to recover Medicaid payments in full from a third-party settlement, up to the full extent of that third-party's legal liability for medical payments. The Medicaid law directs that, whenever "a legal liability is found to exist," the State "*will* seek reimbursement" for the medical assistance it has provided. 42 U.S.C. 1396a(a)(25)(B) (emphasis added). The only exception to that directive is when the costs of recovery can reasonably be expected to exceed the amount reimbursed. *Ibid.* The State, moreover, must seek reimbursement "to the extent of such legal liability"—no more, but also no less. *Ibid.* The beneficiary's duty to cooperate likewise extends to assisting the State in "pursuing[] any third party who may be liable to pay for care and services" provided under the Medicaid program, to the extent of that liability. 42 U.S.C. 1396k(a)(1)(C).

Medicaid's assignment provision gives effect to that mandate. Section 1396k requires a Medicaid beneficiary, as a condition of receiving benefits, to assign to the State "any rights" the beneficiary has to any "payment for medical care" from "any third party." 42 U.S.C. 1396k(a)(1)(A). Congress thus charged the States with recovering Medicaid payments from any liable third party in whatever form those payments may take, whether an insurance payment, a court judgment, or a lump-sum settlement.

While the assignment entitles the State to reimbursement of its medical expenses to the extent of the third person's liability, the beneficiary retains the right to payment for any additional medical expenses personally incurred either before or subsequent to Medicaid eligibility and for other damages. See 42 U.S.C. 1396k(b). The State's claim, however, has priority. Only after the State retains the

amount "necessary to reimburse it for medical assistance payments made" will the "remainder" "be paid to such individual." *Ibid.* "Pay[ing] to the agency any support or medical care funds received that are covered by the assignment of rights" is an "essential[]" component of the statutorily mandated duty of cooperation. 42 C.F.R. 433.147(b)(4).

The court of appeals held, however, that because respondent had chosen to settle for roughly 18% of all the damages she had alleged, she could force the State to accept just 16.5% of its claim for medical damages. Pet. App. 3, 15. That is wrong. The settlement constitutes "a payment for medical care from any third party," 42 U.S.C. 1396k(a)(1)(A), in "a[] case where such a legal liability [for medical damages] is found to exist," 42 U.S.C. 1396a(a)(25)(B). Indeed, respondent does not dispute that the settlement constitutes a qualifying third-party liability payment, within the meaning of the Medicaid Act, and that both the underlying lawsuit and the settlement included her claim for the medical damages that Medicaid, in fact, paid. Nor is there any dispute that the settlement exhausts insurance coverage or that respondent executed a release of the tortfeasor's liability. J.A. 4-5, 12, 23-24; Pet. C.A. Br. 10.

The only dispute is how to measure the amount of the State's recovery from the funds respondent received. The Medicaid statute resolves that dispute. The State, and the respondent in cooperation with the State, must seek to recover all Medicaid expenditures to the full "extent of such legal liability," 42 U.S.C. 1396a(a)(25)(B); Ark. Code Ann. § 20-77-302(b) (Michie 1991), and not just to the extent of some arbitrary calculation of compromised liability crafted after the fact by the beneficiary. Where the State is notified and given an opportunity to participate in settlement negotiations, it may compromise its claim in appropriate circumstances, based on its assessment of the existence or extent of the defendant's liability. But that is a judgment

for the State to make, pursuing the objectives of and within the limits imposed by the federal Medicaid program.

Where, however, the beneficiary has breached the duty of cooperation and has unilaterally resolved the third parties' liability, the Medicaid statute requires as a default rule that the settlement be presumed to include full compensation of the State's Medicaid claim. That result ensures that the statutory assignment to the State of "any rights" to any "payment for medical care from any third party" remains, as it must, an assignment to the full extent of legal liability, rather than an assignment merely of the beneficiary's post hoc, unilaterally determined compromise valuation of the claim. 42 U.S.C. 1396a(a)(25)(H) (the State "acquire[s] the *rights* of such individual *to payment* by any other party for such health care items or services" as the State has rendered) (emphases added); cf. *United States* v. *Lorenzetti*, 467 U.S. 167, 173-178 (1984).

That approach also recognizes the reality that respondent, in settling the case, had no unilateral capacity to accept anything less than full compensation for Medicaid's expenditures. Because the litigation resolved all potential sources of third-party liability for her injuries, J.A. 4-5, 12, 23-24, the duty of cooperation precluded respondent from omitting or understating the medical damages claim from her lawsuit and attempting to horde for herself the third-party liability payments. And to the extent respondent claimed medical damages, she sought recovery not in her own right, but pursuant to her statutorily imposed duty of cooperation in the pursuit of payments from third parties, 42 U.S.C. 1396k(a)(1)(C), to the full "extent of [their] legal liability" for medical damages, 42 U.S.C. 1396a(a)(25)(B); Ark. Code Ann. § 20-77-302(b). That is because respondent had no independent legal claim for medical damages unless and until Medicaid was fully compensated, having assigned to the State her right to any payment for medical damages

up to the amount of Medicaid expenditures. 42 U.S.C. 1396k(a)(1)(A) and (b).

Thus, having assigned to the State her right to medical damages, respondent had no legal authority or capacity to compromise unilaterally the State's $215,000 claim. That is particularly true here, where respondent settled the case out from under the State despite (i) repeated notifications of the State's claim, J.A. 23-24; (ii) the State's intervention in the litigation, J.A. 24; and (iii) state law requirements that the State be notified of any settlement negotiations, Ark. Code Ann. § 20-77-304(b), and be afforded a "reasonable opportunity to establish its interest" before the settlement is "satisfied," *id.* § 20-77-305(a). While respondent presumably hoped that she would be able, after the fact, to force the State to accept the same compromise of its claim that she was willing to accept for her own claims, she was wrong. And having forsaken her federal and state statutory duties of candid and forthcoming cooperation—simple duties for which she received in exchange $215,000 dollars worth of taxpayer-funded medical care—respondent, rather than the taxpayers, must bear the financial consequences of her actions. Because Arkansas's claim to compensation was not and could not have been compromised by respondent, federal law entitles Arkansas to full payment of its claim, rather than just 16.5% of it. And the State's claim must be paid first. 42 U.S.C. 1396k(b).

3. The Medicaid statute does not require the State to litigate its own claims directly

The court of appeals reasoned (Pet. App. 13) that Arkansas's ability "to pursue directly the third-party tortfeasor for medical expenses" obviated the unfairness of limiting the State's recovery under the settlement agreement. This case proves otherwise. Arkansas attempted to do exactly what the court of appeals prescribed by intervening in the

state court litigation, asserting its claim to compensation, and requesting notice of all future proceedings. J.A. 24. The case nevertheless was settled, the insurance policy was paid out at its liability cap, J.A. 23, and respondent executed a full release in favor of the tortfeasors, J.A. 24, without notice to or participation by the State, Pet. App. 2.[6]

Beyond that, the assignment provision is just one of a number of "reasonable measures," 42 U.S.C. 1396a(a)(25)(A), that States can take to identify and recoup medical payments from liable third parties. Nothing in the statutory text indicates that independent pursuit of an assigned claim is the sole statutorily permitted mode of recovery. *Wilson* v. *State*, 10 P.3d 1061, 1066 n.3 (Wash. 2000), cert. denied, 532 U.S. 1020 (2001). The States, in fact, have experimented with a variety of approaches to this problem, many of which the Secretary has endorsed, see Health Care Fin. Admin., Dep't of Health & Human Servs., *Third Party Liability in the Medicaid Program: A Guide to Successful State Agency Practices* (Sept. 1990).

Moreover, participation in private litigation has some advantages over independent litigation by the State. While the assignment of rights to the State provides a legal basis for bringing suit, the State comes to the case armed only with its proof of damages, but no independent proof of liability. The State is largely, if not entirely, dependent upon the beneficiary for that evidence, and the State could reasonably conclude that a beneficiary will be most effective in establishing liability when the beneficiary's own separate claims for relief are also on the line. In addition, consolidating the State's and beneficiary's claims in a single suit avoids duplicative and potentially inconsistent judgments

[6] The State did not sign a release, J.A. 24, and it is not apparent that a beneficiary could release the State's claim, at least if the third party knew or should have known of the State's claim.

and allows the States to devote Medicaid resources to medical care rather than litigation.[7]

B. Full Recovery Of The State's Medical Expenses From A Settlement Is Consistent With Medicaid's Anti-Lien Provision

The Medicaid statute prohibits States from imposing any lien "against the property of any individual prior to his death on account of medical assistance paid." 42 U.S.C. 1396p(a)(1). Central to the court of appeals' analysis was its assumption (Pet. App. 6-14) that Arkansas's effort to recover anything more than the percentage of the settlement unilaterally allocated to medical damages by respon-

[7] Courts occasionally conduct post-settlement hearings to allocate settlements between taxable and non-taxable income categories, see *Commissioner* v. *Schleier*, 515 U.S. 323, 334, 336 (1995). See, *e.g.*, *Delaney* v. *Commissioner*, 99 F.3d 20 (1st Cir. 1996); *Dotson* v. *United States*, 87 F.3d 682 (5th Cir. 1996). Such post hoc hearings are not a sufficient remedy in this instance, however. Unlike taxpayers, the Medicaid beneficiary has actually assigned the right to payment for medical damages to the State and has a statutory duty of full cooperation in litigation, including in the settlement proceedings. Secret settlements that effectively extinguish or impair the State's claim are not the type of "good-faith" settlements that are amenable to reliable post hoc review in court. *Dotson*, 87 F.3d at 687. By that point, the incentives of the beneficiary (who has already evidenced disloyalty to the State's claim) would be to use her control over the relevant evidence of liability to play up her own contributory negligence and to allocate claims artificially to other damage categories, in order "to benefit at the expense of the government." *Ibid.*

If the States are involved up front in the settlement, by contrast, the beneficiary's inherent interest in maximizing the recovery will be better aligned with the State's, and the State will have more information on which to assess for itself the full extent of the third party's liability for medical damages. Furthermore, the tax cases ask the more objective and tangible question of whether damages were paid "on account of personal physical injuries or physical sickness," rather than economic or contractual injuries. 26 U.S.C. 104(a)(2). Here, the hearing would have to answer how unproven personal injury claims might have been subdivided into different manifestations of that injury, as discounted by proof difficulties and myriad other, subjective and individualized considerations that prompt plaintiffs to forgo trials.

dent would violate that anti-lien provision. That assumption is wrong for four reasons.

1. The lien does not attach to the beneficiary's property

Arkansas's lien does not implicate Medicaid's anti-lien provision because it does not attach "against the property" of the Medicaid beneficiary. 42 U.S.C. 1396p(a)(1). Arkansas's claim attaches only to a "payment for medical care from a[] third party," which the beneficiary had previously assigned to the State. 42 U.S.C. 1396k(a)(1)(A). That "payment for medical care" is, at its origin, the property of the paying third party, and thereafter the property of the State. The sole operative effect of Arkansas's lien provision is to ensure that, to the extent the third party's payment passes through the recipient's hands en route to the State, it comes with the State's lien already attached. See Ark. Code Ann. § 20-77-307(c) (assignment gives rise to an automatic "statutory lien" on "any settlement" "received by the recipient *from a third party*") (emphasis added).[8]

Indeed, the Arkansas Supreme Court has held that, under Arkansas's Medicaid assignment and lien provisions, "the funds recipients received were not their 'property,'" because "the settlement funds from the third party have already been 'dedicated' to the Medicaid fund." *Arkansas Dep't of Human Servs.* v. *Estate of Ferrel*, 984 S.W.2d 807, 810 (1999). Accordingly, as that decision makes clear, a lien attaches to the property of a liable third party upon its payment to a Medicaid beneficiary. *Id.* at 811. The payment from the third party does not become property of the bene-

[8] A property owner can impose a lien on its own property when, as here, equity requires it "to prevent a failure of justice." *Gould* v. *Day*, 94 U.S. 405, 413 (1876).

ficiary subject to the anti-lien provision, if at all, until after the State's Medicaid claim is paid in full.[9]

2. Respondent has no federally recognized property right

Whatever the state-law label, the question of whether a beneficiary's interest in a settlement amount attributable to the State's medical damages claim constitutes "property" within the meaning of Medicaid's anti-lien provision is a question of federal law. In *United States* v. *Craft*, 535 U.S. 274 (2002), this Court held that, in construing a federal statutory lien provision, "state law labels are irrelevant to the federal question of which bundles of rights constitute property" subject to the law. *Id.* at 279; see *id.* at 288; see also *Drye* v. *United States*, 528 U.S. 49, 58 (1999) ("The question whether a state-law right constitutes 'property' or 'rights to property' [under a federal statute] is a matter of federal law.") (citation omitted); cf. *Dames & Moore* v. *Regan*, 453 U.S. 654, 674 n.6 (1981).

Under the Medicaid Act, the beneficiary has no sufficient rights in the amount of the settlement available to pay the State's medical damages claim that would give rise to a federally protected property interest under the anti-lien provision. To the contrary, respondent assigned away "any rights" she had in any "payment for medical care from any third party." 42 U.S.C. 1396k(a)(1)(A). Arkansas did permit respondent to litigate the medical damages claim along with her own separate damages claims in her state court tort suit.[10] But federal and state law required respondent

[9] See 42 U.S.C. 1396k(b); *Ferrel*, 984 S.W.2d at 811 (Arkansas's "ability to recover Medicaid payments from insurance settlements * * * is superior to that of the recipient even when the settlement does not pay all the recipient's medical costs"); see generally *Wilson*, 10 P.3d at 1065 n.2; *Houghton*, 57 P.3d at 1069; *Cricchio* v. *Pennisi*, 683 N.E.2d 301, 305 (N.Y. 1997).

[10] See Ark. Code Ann. § 20-77-302; *Richards*, 604 S.E.2d at 819 (because "an assignor can sue with the consent of the assignee[,] * * * recipients have the

to conduct that litigation consonant with her legal obligation "to assist the State in pursuing[] any third party" recovery for medical damages first, 42 U.S.C. 1396k(a)(1)(C), and to the full "extent of such legal liability," 42 U.S.C. 1396a(a)(25)(B); see 42 U.S.C. 1396k(b). That authority did not include secretly and unilaterally compromising Arkansas's claim, in contravention of both state law and the federal mandate of good-faith cooperation. In these circumstances, respondent similarly lacked a cognizable interest in the settlement money once she had it, because state law had already attached a lien to the funds paid by the third party to the extent necessary for Medicaid compensation. Respondent thus "was on notice of the contingent nature" of her possession of such funds. *Dames & Moore*, 453 U.S. at 673. Accordingly, with respect to third-party payments to resolve claims for medical damages, respondent possessed none of the rights of control, dominion, or exclusion that are the hallmarks of "property." See *Craft*, 535 U.S. at 283; *Drye*, 528 U.S. at 61.

The court of appeals nevertheless found (Pet. App. 6) a property interest because Arkansas's lien arises "*after* Ahlborn receive[d] her settlement from the tortfeasor." The Arkansas Supreme Court has ruled otherwise as a matter of state law, holding that the legal effect of the lien precedes the beneficiary's receipt of funds, prevents her from obtaining a property interest in the funds, and even permits an independent action by the State against the tortfeasor. *Ferrel*, 984 S.W.2d at 810-811. Obviously, if the State's rights under the lien provision arose only after the litigation was concluded and a settlement paid, "[t]he lien itself" would *not* "allow[] [Arkansas] to pursue the third

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power to pursue claims against tortfeasors for all injuries, including medical expenses").

party." *Id.* at 811. That construction of state law by the State's highest court is "authoritative."[11]

Furthermore, quite aside from the operation of state law, the federal Medicaid statute required respondent to assign "any rights" to "payment[s] for medical care" to the State, and to cooperate fully in getting those funds into the State's hands. 42 U.S.C. 1396k(a)(1)(A) and (C). One "essential" aspect of cooperation is "[p]ay[ing] to the agency any support or medical care funds received that are covered by the assignment of rights." 42 C.F.R. 433.147(b)(4). Accordingly, when respondent received funds encompassed by the assignment provision, federal law imposed a constructive trust or equitable lien on those funds that obligated her to pass them through to the State.[12]

In addition, the Medicaid anti-lien provision expressly permits a lien to be imposed, pursuant to a court order, "on account of benefits incorrectly paid on behalf of such individual." 42 U.S.C. 1396p(a)(1)(A). Respondent's backdoor settlement of the medical damages claim and retention for herself of settlement funds attributable to medical care resulted in obstruction and attrition, rather than effectuation, of the right assigned to the State and violated her duty of cooperation. The district court's order upholding Arkansas's lien properly enforced the statutory conditions

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[11] See *National Cable & Telecomms. Ass'n* v. *Brand X Internet Servs.*, 125 S. Ct. 2688, 2701 (2005); *O'Brien* v. *Skinner*, 414 U.S. 524, 531 (1974).

[12] See *Great-West Life & Annuity Ins. Co.* v. *Knudson*, 534 U.S. 204, 213 (2002); *Harris Trust & Sav. Bank* v. *Salomon Smith Barney Inc.*, 530 U.S. 238, 250-251 (2000); George T. Bogert, *Trusts* § 77, at 287 (6th ed. 1987) (constructive trust may be imposed where the "trustee's sole duty is to transfer the title and possession [of trust property] to the beneficiary"); see generally George T. Bogert, *Trusts and Trustees* §§ 471, 484 (2d ed. rev. 1978 & Supp. 2004); *id.* § 471, at 6 ("[T]he defendant has been under an equitable duty to give the complainant the benefit of the property ever since the defendant began to hold unjustly.").

for her receipt of benefits, and thereby prevented those benefits from having been "incorrectly paid," *ibid.*[13]

The court of appeals further reasoned (Pet. App. 13) that Medicaid beneficiaries are not required to assign their rights "to the extent of the third party's liability," but only "to third-party payments for medical care." That is true, but beside the point here. There is no dispute that the settlement qualified as a "third-party payment[] for medical care." *Ibid.*[14] The only question is how much of the undifferentiated settlement payment is attributable to medical care. The court of appeals presumed that the settlement embodied only a percentage (16.5%) of Arkansas's claim for medical damages, and on that basis held that the State's effort to collect any more than that designated percentage was an impermissible attempt to impose a lien on respondent's property interest in payment of her other, non-assigned claims. See *id.* at 6, 12, 13.

But the court of appeals' starting presumption was wrong. Respondent had no legal authority to compromise Arkansas's claim, and any attempt to do so unilaterally and without affording the State a "reasonable opportunity to establish its interest" before the settlement was "satisfied" violated both state law, Ark. Code Ann. §§ 20-77-302, 20-77-

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[13] See C.A. App. 20; cf. *Rose* v. *Rose*, 481 U.S. 619, 634 (1987) (permitting contempt proceedings to recover veterans' benefits, despite anti-lien provision, where the claim "would further, not undermine," congressional purpose).

[14] When cases go to trial and a court or jury assigns a specific dollar value to the defendants' liability for medical damages, the Secretary ordinarily accepts that finding as controlling, even if the amount proves to be less than the medical expenses incurred by Medicaid. Cf. Centers for Medicare & Medicaid Servs., *Medicare Intermediary Manual*, Pt. 3, Ch. V, § 3418.7 (Dec. 1994). That might occur when, for example, the beneficiary's own negligence diminished the defendant's liability for medical damages. But different considerations might obtain if the State had not participated and the beneficiary had failed to present evidence of the full extent of the payment by Medicaid for medical expenses.

305, and her federal-law duty of cooperation, 42 U.S.C. 1396k(a)(1)(C), 42 C.F.R. 433.147(b)(4). And even if state law had authorized respondent to compromise Arkansas's share of the Medicaid reimbursement, respondent had no power to compromise the *federal government's* claim to approximately 74% of the recovery. Quite the opposite, the Secretary, through the Departmental Appeals Board (Board), has twice issued published decisions holding that state law may not authorize compromise of the federal government's share while allocating funds to the beneficiary's other damages claims. See *In re Washington State Dep't of Social & Health Servs.*, Dec. No. 1561 (HHS Feb. 7, 1996), Pet. App. 45-67; *In re California Dep't of Health Servs.*, Dec. No. 1504 (HHS Jan. 5, 1995), Pet. App. 68-86. For that reason, federal law treats the Medicaid claim as uncompromised and due in full from a settlement.[15]

The court of appeals' conclusion that respondent's after-the-fact and self-interested proposed allocation of only 6.5% of the settlement (16.5% of the Medicaid claim) to medical damages should be controlling also makes no practical sense. The court offered no basis, in state or federal law, for concluding that a lump-sum settlement could be apportioned in a legally binding manner without any adjudication of the issue and without notice and opportunity for the State meaningfully to participate. See *Zinman* v. *Shalala*, 67 F.3d 841, 846 (9th Cir. 1995) ("Apportionment * * * would either require a factfinding process to determine actual damages or would place Medicare at the mercy of a victim's or personal injury attorney's estimate of damages.").

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[15] While the States, in settlement proceedings in which they participate, are "free to allow recipients to retain the state's share of the recovery," they may not permit the beneficiary to retain payments from a settlement before the federal government's share of the medical damages is recovered. *Washington*, *supra*, Pet. App. 63; *California*, *supra*, Pet. App. 85; Health Care Fin. Admin., Dep't of Health & Human Servs., *Dallas Regional Medical Services Letter No. 88-23* (June 1, 1998), Pet. App. 90-91.

Moreover, generally speaking, proof of past medical damages is easier than many other elements of a tort recovery, such as respondent's claims for prospective economic loss or pain and suffering. The medical costs incurred are specific, identified, and carefully documented in medical records; they do not entail speculation; they are easily reduced to concrete dollar measurements; and they are not readily susceptible to self-interested inflation or manipulation. Indeed, it is usually the ready verifiability of the medical claims that lays the groundwork for assertion of the inherently speculative pain and suffering and prospective economic harms. In any event, any doubt about the amount of medical damages included in the settlement must be resolved against the respondent, who crafted the agreement in secret and deliberately excluded the State in contravention of state and federal law, and who has better access to the facts needed to establish actual liability. Cf. *Schaffer* v. *Weast*, No. 04-698 (Nov. 14, 2005), slip op. 10.

3. The anti-lien provision protects, but does not independently define, property rights

At bottom, Arkansas's demand that its claim be compensated in full from the settlement funds is not an attempt to encroach on respondent's property, but an effort to protect its own property interest in the face of respondent's calculated evasion of her legal obligations. The court of appeals' reliance on Medicaid's anti-lien provision under those circumstances was misplaced. The protections of the anti-lien provision are triggered only after a property right has been recognized by federal law. The anti-lien provision says nothing about the predicate question of whether a property right exists and, in particular, about where the State's property interests stop and the beneficiary's property interests begin in an undifferentiated lump-sum settlement of third-party liability claims.

That question is answered by Medicaid's third-party liability provisions, which (i) unequivocally assign all rights to third-party payments for medical care to the States, to the full extent of Medicaid payments, (ii) mandate candid and forthcoming cooperation by Medicaid beneficiaries in collecting those payments, and (iii) grant the Medicaid claim a priority in the distribution of any third-party payments recovered as a result of that assignment and cooperative litigation process. In the absence of a determination in which the State participates—or of any other specific evidence satisfactory to the State and considered reliable by the Secretary that limits the third parties' liability for medical damages—federal law accorded Arkansas a priority right to full compensation of its Medicaid claim out of the third parties' payment of damages. Nothing in respondent's unilateral settlement process could have diminished the State's right or enhanced respondent's claim to those funds. The anti-lien provision takes property rights as it finds them. It does not transform, through unilateral settlement, the State's rights under Medicaid's third-party liability provisions into federally protected property rights of the beneficiary.

C. The Secretary's Harmonization of Medicaid's Provisions Merits Deference

1. The court of appeals' construction of the intersecting obligations imposed by the Medicaid statute's third-party liability and anti-lien provisions puts Medicaid at war with itself, by reading the anti-lien provision as protecting what the assignment and cooperation requirements forbid. By contrast, the Secretary's established interpretation of the anti-lien and third-party liability provisions as respecting the property lines drawn by the third-party liability provisions harmonizes those provisions, and does so in a manner that gives full effect to Congress's purpose that Medicaid serve as the payer of last resort. That approach is consis-

tent with the "cardinal rule that a statute is to be read as a whole," *King* v. *St. Vincent's Hosp.*, 502 U.S. 215, 221 (1991), and with the Court's obligation "to make sense rather than nonsense" out of the statutory scheme, *West Va. Univ. Hosps., Inc.* v. *Casey*, 499 U.S. 83, 101 (1991). That reading also accords with this Court's specific recognition that anti-lien provisions within the Social Security Act should not be read to forbid what the substantive provisions of the law expressly permit. See *Washington State Dep't of Social & Health Servs.* v. *Guardianship Estate of Keffeler*, 537 U.S. 371, 383-385 & n.7 (2003) (Social Security Act's anti-lien provision does not prohibit payments that the representative payee provisions authorize).

The Secretary's interpretation and implementation of the third-party liability provisions in the context of lump-sum settlement agreements, moreover, merits deference because of "the interstitial nature of the legal question, the related expertise of the Agency, the importance of the question to administration of the statute, the complexity of that administration, and the careful consideration the Agency has given the question over a long period of time." *Barnhart* v. *Walton*, 535 U.S. 212, 222 (2002); see *Auer* v. *Robbins*, 519 U.S. 452 (1997).

The court of appeals withheld deference because it viewed (Pet. App. 11) the Secretary's interpretation as inconsistent with the plain language of the anti-lien provision. But if the statutory text says anything unambiguously, see *Gray Panthers*, 453 U.S. at 43 (noting that the Social Security Act's "Byzantine construction * * * makes the Act almost unintelligible to the uninitiated") (internal quotation marks & citation omitted), it says that the State must recover the full extent of third party liability for medical damages, not its privately and unilaterally compromised value, and that the beneficiary must cooperate in, rather than undermine, that endeavor. The court of appeals' read-

ing of the anti-lien provision would fatally undermine the specific and targeted full-recovery and assignment provisions. Reading the anti-lien provision as inapplicable to recoveries of medical damages, by contrast, would allow that provision to continue to play an important role in other contexts, such as preventing claims against a beneficiary's inheritance. Beyond that, nothing in the text of the Medicaid Act speaks directly to how the third-party liability and anti-lien provisions are to be implemented in the context of settlement awards, and such silence normally creates, rather than resolves, ambiguity. *Barnhart*, 535 U.S. at 218. How to implement those provisions when the State is confronted with a lump-sum settlement, and how the States' recoupment obligations and the beneficiaries' duty of cooperation are defined present the very type of "complex and highly technical regulatory [matters]" that the Secretary has been "granted exceptionally broad authority" to address. *Blumer*, 534 U.S. at 497 (citations omitted). In this case, the Secretary's interpretation is embodied not only in informal agency guidance, see Pet. App. 87-89; J.A. 31-33, 37-38, but also in formal adjudications by the Board, see 45 C.F.R. 16.1 to 16.23 & App. A; 42 C.F.R. 430.42(b).

In *California*, *supra*, and *Washington*, *supra*, the Board interpreted the Medicaid Act's third-party liability provisions to require that Medicaid be reimbursed in full from a settlement award before those funds could be allocated to other purposes, such as compensating the beneficiary for pain and suffering or other damages. In *California*, the Board found invalid a state law that, much like the mathematical formula that the court of appeals endorsed here, automatically set aside a percentage of settlement proceeds for the beneficiaries' own use, without respect to whether Medicaid had been fully reimbursed or to the actual extent of the third party's liability. Pet. App. 68-86.

The Board explained that the fundamental premise of the third-party liability provisions is that, "where a third party has caused the need for medical care[] and is liable for its payment, the Act looks to that third party to reimburse the public." *Id.* at 80-81. The Board also concluded that the assignment and cooperation provisions give Medicaid "superior status to the recipient in relation to the tortfeasor to recover [medical] costs," and allow the Secretary "to characterize recoveries from third parties first as payments for medical care." *Id.* at 81. Similarly, in *Washington*, *supra*, the Board concluded that discretionary, case-by-case reductions in Medicaid collections to ensure payment of other damages to the beneficiary are impermissible because, "where there is a third party that is responsible for paying a recipient's medical expenses, the recipient may not recover money for him/herself until the federal government is reimbursed for its expenditures for the recipient's medical care." *Id.* at 50, 54.

As the Board recognized (*California*, *supra*, Pet. App. 75, 78), the State's claim must be paid first not because the State may claim damages beyond the extent of the third party's liability for medical damages, but because federal law affords the State's claim a payment priority in the distribution of settlement funds. See 42 U.S.C. 1396k(b); 42 C.F.R. 433.154; see *Washington*, *supra*, Pet. App. 54 (the Secretary "has not taken the position that a recipient assigns or loses his/her right to seek compensation for injuries beyond the cost of medical care," but has only required States "to assert a collection priority").

2. The Secretary's interpretation not only reasonably interprets the statutory text, but also furthers the purpose of the third-party liability provisions, which is "to make Medicaid the payor of last resort where there is a liable third party." *California*, *supra*, Pet. App. 76. "There are limited resources to spend on welfare," *Gray Panthers*, 453

U.S. at 48, and the Secretary's interpretation promotes overall fairness in the provision of the available benefits. Requiring that Medicaid be reimbursed first ensures that tortfeasors, who have "caused the need for medical care and [are] liable for its payment," cannot force the public to cover the victim's medical costs. *Washington*, *supra*, Pet. App. 54. In addition, the Secretary's position equalizes the positions of tort victims who receive third-party payments before and after medical assistance is received. Accepting the private parties' compromise e aluation of medical assistance claims whenever the third-party payment is made after the State has provided care would "create an anomalous situation" in which Medicaid applicants could be disqualified for eligibility because of funds obtained through prior personal injury settlements, "but Medicaid recipients could shield such funds from recoupment by the Department after having received significant public assistance." *Calvanese* v. *Calvanese*, 710 N.E.2d 1079, 1082 (N.Y.), cert. denied, 528 U.S. 928 (1999).

Finally, the Secretary's position takes account of the fact that respondent received substantial medical benefits at public expense, and the government provided those benefits only because of the beneficiary's inability to pay and "on the condition that it would be reimbursed" from any payments by a third party liable for her medical care. *California*, *supra*, Pet. App. 81. Allowing the full "extent of [a third party's] legal liability" for medical damages, 42 U.S.C. 1396a(a)(25)(B), to be carved up between Medicaid reimbursement and the beneficiary would leave the taxpayers picking up more of the beneficiary's tab for medical expenses, while the beneficiary diverted available compensation from the third party to herself. "If Medicaid had not paid [the beneficiaries'] medical expenses, these recipients would have both unrestricted access to their settlements and enormous medical debts to be paid from those settle-

ments." *California, supra*, Pet. App. 85. Such an approach also would promote "manipulation of tort awards by recipients," who could "prevent the public from being reimbursed" for the cost of their medical care by the manner in which they allocate their settlements. *Id.* at 81; see *Richards* v. *Georgia Dep't of Cmty. Health*, 604 S.E.2d 815, 818 (Ga. 2004) (refusing to read the statute to "allow a Medicaid recipient to negotiate a tort settlement structured in such a way so as to reflect no, or minimal, compensation for medical expenses, * * * [which] would be blatantly unfair to th[e] taxpayers, and is contrary to the intent of the federal statutes"). Permitting a Medicaid beneficiary to insist, after benefits already have been received, that settlement payments are not compensation for medical bills, when, as a practical matter, those same funds would have to be used to pay outstanding medical bills if Medicaid had not stepped in, would render the beneficiary's acceptance of the assignment and cooperation obligations an empty gesture.

CONCLUSION

The judgment of the court of appeals should be reversed.

Respectfully submitted.

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NOVEMBER 2005

APPENDIX

1. 42 U.S.C. 1396a provides in pertinent part:

State plans for medical assistance

(a) Contents

A State plan for medical assistance must–

* * * * *

(25) provide–

(A) that the State or local agency administering such plan will take all reasonable measures to ascertain the legal liability of third parties (including health insurers, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1167(1)], service benefit plans, and health maintenance organizations) to pay for care and services available under the plan, including–

(i) the collection of sufficient information (as specified by the Secretary in regulations) to enable the State to pursue claims against such third parties, with such information being collected at the time of any determination or redetermination of eligibility for medical assistance, and

(ii) the submission to the Secretary of a plan (subject to approval by the Secretary) for pursuing claims against such third parties, which plan shall be integrated with, and be monitored as a part of the Secretary's review of, the State's mechanized claims processing

and information retrieval systems required under section 1396b(r) of this title;

(B) that in any case where such a legal liability is found to exist after medical assistance has been made available on behalf of the individual and where the amount of reimbursement the State can reasonably expect to recover exceeds the costs of such recovery, the State or local agency will seek reimbursement for such assistance to the extent of such legal liability;

(C) that in the case of an individual who is entitled to medical assistance under the State plan with respect to a service for which a third party is liable for payment, the person furnishing the service may not seek to collect from the individual (or any financially responsible relative or representative of that individual) payment of an amount for that service (i) if the total of the amount of the liabilities of third parties for that service is at least equal to the amount payable for that service under the plan (disregarding section 1396o of this title), or (ii) in an amount which exceeds the lesser of (I) the amount which may be collected under section 1396o of this title, or (II) the amount by which the amount payable for that service under the plan (disregarding section 1396o of this title), exceeds the total of the amount of the liabilities of third parties for that service;

(D) that a person who furnishes services and is participating under the plan may not refuse to furnish services to an individual (who is entitled to have payment made under the plan for the services the person furnishes) because of a third party's potential liability for payment for the service;

(E) that in the case of prenatal or preventive pediatric care (including early and periodic screening and diagnosis services under section 1396d(a)(4)(B) of this title) covered under the State plan, the State shall—

(i) make payment for such service in accordance with the usual payment schedule under such plan for such services without regard to the liability of a third party for payment for such services; and

(ii) seek reimbursement from such third party in accordance with subparagraph (B);

(F) that in the case of any services covered under such plan which are provided to an individual on whose behalf child support enforcement is being carried out by the State agency under part D of subchapter IV of this chapter, the State shall—

(i) make payment for such service in accordance with the usual payment schedule under such plan for such services without regard to any third-party liability for payment for such services, if such third-party liability is derived (through insurance or otherwise) from the parent whose obligation to pay support is being enforced by such agency, if payment has not been made by such third party within 30 days after such services are furnished; and

(ii) seek reimbursement from such third party in accordance with subparagraph (B);

(G) that the State prohibits any health insurer (including a group health plan, as defined in section 607(1) of the Employee Retirement Income Security Act of 1974 [29 U.S.C.A. § 1167(1)], a service

benefit plan, and a health maintenance organization), in enrolling an individual or in making any payments for benefits to the individual or on the individual's behalf, from taking into account that the individual is eligible for or is provided medical assistance under a plan under this subchapter for such State, or any other State; and

(H) that to the extent that payment has been made under the State plan for medical assistance in any case where a third party has a legal liability to make payment for such assistance, the State has in effect laws under which, to the extent that payment has been made under the State plan for medical assistance for health care items or services furnished to an individual, the State is considered to have acquired the rights of such individual to payment by any other party for such health care items or services;

* * * * *

(45) provide for mandatory assignment of rights of payment for medical support and other medical care owed to recipients, in accordance with section 1396k of this title;

* * * * *

2. 42 U.S.C. 1396k provides:

Assignment, enforcement, and collection of rights of payments for medical care; establishment of procedures pursuant to State plan; amounts retained by State

(a) For the purpose of assisting in the collection of medical support payments and other payments for medical care owed to recipients of medical assistance under the State plan approved under this subchapter, a State plan for medical assistance shall—

(1) provide that, as a condition of eligibility for medical assistance under the State plan to an individual who has the legal capacity to execute an assignment for himself, the individual is required—

(A) to assign the State any rights, of the individual or of any other person who is eligible for medical assistance under this subchapter and on whose behalf the individual has the legal authority to execute an assignment of such rights, to support (specified as support for the purpose of medical care by a court or administrative order) and to payment for medical care from any third party;

(B) to cooperate with the State (i) in establishing the paternity of such person (referred to in subparagraph (A)) if the person is a child born out of wedlock, and (ii) in obtaining support and payments (described in subparagraph (A)) for himself and for such person, unless (in either case) the individual is described in section 1396a(l)(1)(A) of this title or the individual is found to have good cause for refusing to cooperate as determined by the State agency in accordance with standards prescribed by the Secretary, which standards

shall take into consideration the best interests of the individuals involved; and

(C) to cooperate with the State in identifying, and providing information to assist the State in pursuing, any third party who may be liable to pay for care and services available under the plan, unless such individual has good cause for refusing to cooperate as determined by the State agency in accordance with standards prescribed by the Secretary, which standards shall take into consideration the best interests of the individuals involved; and

(2) provide for entering into cooperative arrangements (including financial arrangements), with any appropriate agency of any State (including, with respect to the enforcement and collection of rights of payment for medical care by or through a parent, with a State's agency established or designated under section 654(3) of this title) and with appropriate courts and law enforcement officials, to assist the agency or agencies administering the State plan with respect to (A) the enforcement and collection of rights to support or payment assigned under this section and (B) any other matters of common concern.

(b) Such part of any amount collected by the State under an assignment made under the provisions of this section shall be retained by the State as is necessary to reimburse it for medical assistance payments made on behalf of an individual with respect to whom such assignment was executed (with appropriate reimbursement of the Federal Government to the extent of its participation in the financing of such medical assistance), and the remainder of such amount collected shall be paid to such individual.

3. 42 U.S.C.A. 1396p(a) provides in pertinent part:

Liens, adjustments and recoveries, and transfers of assets

(a) Imposition of lien against property of an individual on account of medical assistance rendered to him under a State plan

(1) No lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan, except—

(A) pursuant to the judgment of a court on account of benefits incorrectly paid on behalf of such individual, or

(B) in the case of the real property of an individual—

(i) who is an inpatient in a nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of his income required for personal needs, and

(ii) with respect to whom the State determines, after notice and opportunity for a hearing (in accordance with procedures established by the State), that he cannot reasonably be expected to be discharged from the medical institution and to return home,

except as provided in paragraph (2).

(2) No lien may be imposed under paragraph (1)(B) on such individual's home if—

(A) the spouse of such individual,

(B) such individual's child who is under age 21, or (with respect to States eligible to participate in the State program established under subchapter XVI of this chapter) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1382c of this title, or

(C) a sibling of such individual (who has an equity interest in such home and who was residing in such individual's home for a period of at least one year immediately before the date of the individual's admission to the medical institution), is lawfully residing in such home.

(3) Any lien imposed with respect to an individual pursuant to paragraph (1)(B) shall dissolve upon that individual's discharge from the medical institution and return home.

* * * * *

4. 42 C.F.R. 433.136 provides in pertinent part:

Definitions.

For the purposes of this subpart–

* * * * *

Third party means any individual, entity or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished under a State plan.

* * * * *

5. 42 C.F.R. 433.138 provides:

Identifying liable third parties.

(a) *Basic provisions.* The agency must take reasonable measures to determine the legal liability of the third parties who are liable to pay for services furnished under the plan. At a minimum, such measures must include the requirements specified in paragraphs (b) through (k) of this section, unless waived under paragraph (l) of this section.

(b) *Obtaining health insurance information: Initial application and redetermination processes for Medicaid eligibility.* (1) If the Medicaid agency determines eligibility for Medicaid, it must, during the initial application and each redetermination process, obtain from the applicant or recipient such health insurance information as would be useful in identifying legally liable third party resources so that the agency may process claims under the third party liability payment procedures specified in § 433.139 (b) through (f). Health insurance information may include, but is not limited to, the name of the policy holder, his or her

relationship to the applicant or recipient, the social security number (SSN) of the policy holder, and the name and address of insurance company and policy number.

(2) If Medicaid eligibility is determined by the Federal agency administering the supplemental security income program under title XVI in accordance with a written agreement under section 1634 of the Act, the Medicaid agency must take the following action. It must enter into an agreement with CMS or must have, prior to February 1, 1985, executed a modified section 1634 agreement that is still in effect to provide for—

(i) Collection, from the applicant or recipient during the initial application and each redetermination process, of health insurance information in the form and manner specified by the Secretary; and

(ii) Transmittal of the information to the Medicaid agency.

(3) If Medicaid eligibility is determined by any other agency in accordance with a written agreement, the Medicaid agency must modify the agreement to provide for—

(i) Collection, from the applicant or recipient during the initial application and each redetermination process, of such health insurance information as would be useful in identifying legally liable third party resources so that the Medicaid agency may process claims under the third party liability payment procedures specified in § 433.139(b) through (f). Health insurance information may include, but is not limited to, those elements described in paragraph (b)(1) of this section; and

(ii) Transmittal of the information to the Medicaid agency.

(c) *Obtaining other information.* Except as provided in paragraph (l) of this section, the agency must, for the purpose of implementing the requirements in paragraphs (d)(1)(ii) and (d)(4)(i) of this section, incorporate into the eligibility case file the names and SSNs of absent or custodial parents of Medicaid recipients to the extent such information is available.

(d) *Exchange of data.* Except as provided in paragraph (l) of this section, to obtain and use information for the purpose of determining the legal liability of the third parties so that the agency may process claims under the third party liability payment procedures specified in § 433.139(b) through (f), the agency must take the following actions:

(1) Except as specified in paragraph (d)(2) of this section, as part of the data exchange requirements under § 435.945 of this chapter, from the State wage information collection agency (SWICA) defined in § 435.4 of this chapter and from the SSA wage and earnings files data as specified in § 435.948(a)(2) of this chapter, the agency must—

(i) Use the information that identifies Medicaid recipients that are employed and their employer(s); and

(ii) Obtain and use, if their names and SSNs are available to the agency under paragraph (c) of this section, information that identifies employed absent or custodial parents of recipients and their employer(s).

(2) If the agency can demonstrate to CMS that it has an alternate source of information that furnishes

information as timely, complete and useful as the SWICA and SSA wage and earnings files in determining the legal liability of third parties, the requirements of paragraph (d)(1) of this section are deemed to be met.

(3) The agency must request, as required under § 435.948(a)(6)(i), from the State title IV-A agency, information not previously reported that identifies those Medicaid recipients that are employed and their employer(s).

(4) Except as specified in paragraph (d)(5) of this section, the agency must attempt to secure agreements (to the extent permitted by State law) to provide for obtaining—

(i) From State Workers' Compensation or Industrial Accident Commission files, information that identifies Medicaid recipients and, (if their names and SSNs were available to the agency under paragraph (c) of this section) absent or custodial parents of Medicaid recipients with employment-related injuries or illnesses; and

(ii) From State Motor Vehicle accident report files, information that identifies those Medicaid recipients injured in motor vehicle accidents, whether injured as pedestrians, drivers, passengers, or bicyclists.

(5) If unable to secure agreements as specified in paragraph (d)(4) of this section, the agency must submit documentation to the regional office that demonstrates the agency made a reasonable attempt to secure these agreements. If CMS determines that a reasonable attempt was made, the requirements of paragraph (d)(4) of this section are deemed to be met.

(e) *Diagnosis and trauma code edits.* (1) Except as specified under paragraph (e)(2) or (l) of this section, or both, the agency must take action to identify those paid claims for Medicaid recipients that contain diagnosis codes 800 through 999 International Classification of Disease, 9th Revision, Clinical Modification, Volume 1 (ICD-9-CM) inclusive, for the purpose of determining the legal liability of third parties so that the agency may process claims under the third party liability payment procedures specified in § 433.139(b) through (f).

(2) The agency may exclude code 994.6, Motion Sickness, from the edits required under paragraph (e)(1) of this section.

(f) *Data exchanges and trauma code edits: Frequency.* Except as provided in paragraph (l) of this section, the agency must conduct the data exchanges required in paragraphs (d)(1) and (d)(3) of this section in accordance with the intervals specified in § 435.948 of this chapter, and diagnosis and trauma edits required in paragraphs (d)(4) and (e) of this section on a routine and timely basis. The State plan must specify the frequency of these activities.

(g) *Follow-up procedures for identifying legally liable third party resources.* Except as provided in paragraph (l) of this section, the State must meet the requirements of this paragraph.

(1) *SWICA, SSA wage and earnings files, and title IV-A data exchanges.* With respect to information obtained under paragraphs (d)(1) through (d)(3) of this section—

(i) Except as specified in § 435.952(d) of this chapter, within 45 days, the agency must followup (if

appropriate) on such information in order to identify legally liable third party resources and incorporate such information into the eligibility case file and into its third party data base and third party recovery unit so the agency may process claims under the third party liability payment procedures specified in § 433.139 (b) through (f); and

(ii) The State plan must describe the methods the agency uses for meeting the requirements of paragraph (g)(1)(i) of this section.

(2) *Health insurance information and workers' compensation data exchanges.* With respect to information obtained under paragraphs (b) and (d)(4)(i) of this section—

(i) Within 60 days, the agency must followup on such information (if appropriate) in order to identify legally liable third party resources and incorporate such information into the eligibility case file and into its third party data base and third party recovery unit so the agency may process claims under the third party liability payment procedures specified in § 433.139 (b) through (f); and

(ii) The State plan must describe the methods the agency uses for meeting the requirements of paragraph (g)(2)(i) of this section.

(3) *State motor vehicle accident report file data exchanges.* With respect to information obtained under paragraph (d)(4)(ii) of this section—

(i) The State plan must describe the methods the agency uses for following up on such information in order to identify legally liable third party resources so the agency may process claims under the third party

liability payment procedures specified in § 433.139 (b) through (f);

(ii) After followup, the agency must incorporate all information that identifies legally liable third party resources into the eligibility case file and into its third party data base and third party recovery unit; and

(iii) The State plan must specify timeframes for incorporation of the information.

(4) *Diagnosis and trauma code edits.* With respect to the paid claims identified under paragraph (e) of this section—

(i) The State plan must describe the methods the agency uses to follow up on such claims in order to identify legally liable third party resources so the agency may process claims under the third party liability payment procedures specified in § 433.139 (b) through (f) (Methods must include a procedure for periodically identifying those trauma codes that yield the highest third party collections and giving priority to following up on those codes.);

(ii) After followup, the agency must incorporate all information that identifies legally liable third party resources into the eligibility case file and into its third party data base and third party recovery unit; and

(iii) The State plan must specify the time frames for incorporation of the information.

(h) *Obtaining other information and data exchanges: Safeguarding information.* (1) The agency must safeguard information obtained from and exchanged under this section with other agencies in accordance with the requirements set forth in Part 431, Subpart F of this chapter.

(2) Before requesting information from, or releasing information to other agencies to identify legally liable third party resources under paragraph (d) of this section the agency must execute data exchange agreements with those agencies. The agreements, at a minimum, must specify—

(i) The information to be exchanged;

(ii) The titles of all agency officials with the authority to request third party information;

(iii) The methods, including the formats to be used, and the timing for requesting and providing the information;

(iv) The safeguards limiting the use and disclosure of the information as required by Federal or State law or regulations; and

(v) The method the agency will use to reimburse reasonable costs of furnishing the information if payment is requested.

(i) *Reimbursement.* The agency must, upon request, reimburse an agency for the reasonable costs incurred in furnishing information under this section to the Medicaid agency.

(j) *Reports.* The agency must provide such reports with respect to the data exchanges and trauma code edits set forth in paragraphs (d)(1) through (d)(4) and paragraph (e) of this section, respectively, as the Secretary prescribes for the purpose of determining compliance under § 433.138 and evaluating the effectiveness of the third party liability identification system. However, if the State is not meeting the provisions of paragraph (e) of this section because it has been granted a waiver of those provisions under para-

graph (l) of this section, it is not required to provide the reports required in this paragraph.

(k) *Integration with the State mechanized claims processing and information retrieval system. Basic requirement—Development of an action plan.* (1) If a State has a mechanized claims processing and information retrieval system approved by CMS under Subpart C of this part, the agency must have an action plan for pursuing third party liability claims and the action plan must be integrated with the mechanized claims processing and information retrieval system.

(2) The action plan must describe the actions and methodologies the State will follow to—

(i) Identify third parties;

(ii) Determine the liability of third parties;

(iii) Avoid payment of third party claims as required in § 433.139;

(iv) Recover reimbursement from third parties after Medicaid claims payment as required in § 433.139; and,

(v) Record information and actions relating to the action plan.

(3) The action plan must be consistent with the conditions for reapproval set forth in § 433.119. The portion of the plan which is integrated with MMIS is monitored in accordance with those conditions and if the conditions are not met; it is subject to FFP reduction in accordance with procedures set forth in § 433.120. The State is not subject to any other penalty as a result of other monitoring, quality control, or auditing requirements for those items in the action plan.

(4) The agency must submit its action plan to the CMS Regional Office within 120 days from the date CMS issues implementing instructions for the State Medicaid Manual. If a State does not have an approved MMIS on the date of issuance of the State Medicaid Manual but subsequently implements an MMIS, the State must submit its action plan within 90 days from the date the system is operational. The CMS Regional Office approves or disapproves the action plan.

(l) *Waiver of requirements.* (1) The agency may request initial and continuing waiver of the requirements to determine third party liability found in paragraphs (c), (d)(4), (d)(5), (e), (f), (g)(1), (g)(2), (g)(3), and (g)(4) of this section if the State determines the activity to be not cost-effective. An activity would not be cost-effective if the cost of the required activity exceeds the third party liability recoupment and the required activity accomplishes, at the same or at a higher cost, the same objective as another activity that is being performed by the State.

(i) The agency must submit a request for waiver of the requirement in writing to the CMS regional office.

(ii) The request must contain adequate documentation to establish that to meet a requirement specified by the agency is not cost-effective. Examples of documentation are claims recovery data and a State analysis documenting a cost-effective alternative that accomplished the same task.

(iii) The agency must agree, if a waiver is granted, to notify CMS of any event that occurs that

changes the conditions upon which the waiver was approved.

(2) CMS will review a State's request to have a requirement specified under paragraph (l)(1) of this section waived and will request additional information from the State, if necessary. CMS will notify the State of its approval or disapproval determination within 30 days of receipt of a properly documented request.

(3) CMS may rescind a waiver at any time that it determines that the agency no longer meets the criteria for approving the waiver. If the waiver is rescinded, the agency has 6 months from the date of the rescission notice to meet the requirement that had been waived.

6. 42 C.F.R. 433.145 provides:

Assignment of rights to benefits—State plan requirements.

(a) A State plan must provide that, as a condition of eligibility, each legally able applicant or recipient is required to:

(1) Assign to the Medicaid agency his or her rights, or the rights of any other individual eligible under the plan for whom he or she can legally make an assignment, to medical support and to payment for medical care from any third party;

(2) Cooperate with the agency in establishing paternity and in obtaining medical support and payments, unless the individual establishes good cause for not cooperating, and except for individuals described in section 1902(l)(1)(A) of the Act (poverty level preg-

nant women), who are exempt from cooperating in establishing paternity and obtaining medical support and payments from, or derived from, the father of the child born out of wedlock; and

(3) Cooperate in identifying and providing information to assist the Medicaid agency in pursuing third parties who may be liable to pay for care and services under the plan, unless the individual establishes good cause for not cooperating.

(b) A State plan must provide that the requirements for assignments, cooperation in establishing paternity and obtaining support, and cooperation in identifying and providing information to assist the State in pursuing any liable third party under §§ 433.146 through 433.148 are met.

(c) A State plan must provide that the assignment of rights to benefits obtained from an applicant or recipient is effective only for services that are reimbursed by Medicaid.

7. 42 C.F.R. 433.147 provides in pertinent part:

Cooperation in establishing paternity and in obtaining medical support and payments and in identifying and providing information to assist in pursuing third parties who may be to pay.

(a) *Scope of requirement.* The agency must require the individual who assigns his or her rights to cooperate in–

(1) Establishing paternity of a child born out of wedlock and obtaining medical support and payments for himself or herself and any other person for whom

the individual can legally assign rights, except that individuals described in section 1902(l)(1)(A) of the Act (poverty level pregnant women) are exempt from these requirements involving paternity and obtaining medical support and payments from, or derived from, the father of the child born out of wedlock; and

(2) Identifying and providing information to assist the Medicaid agency in pursuing third parties who may be liable to pay for care and services under the plan.

(b) *Essentials of cooperation.* As part of a cooperation, the agency may require an individual to—

(1) Appear at a State or local office designated by the agency to provide information or evidence relevant to the case;

(2) Appear as a witness at a court or other proceeding;

(3) Provide information, or attest to lack of information, under penalty of perjury;

(4) Pay to the agency any support or medical care funds received that are covered by the assignment of rights; and

(5) Take any other reasonable steps to assist in establishing paternity and securing medical support and payments, and in identifying and providing information to assist the State in pursuing any liable third party.

* * * * *

8. 42 C.F.R. § 433.154 provides:

Distribution of collections.

The agency must distribute collections as follows–

(a) To itself, an amount equal to State Medicaid expenditures for the individual on whose right the collection was based.

(b) To the Federal Government, the Federal share of the State Medicaid expenditures, minus any incentive payment made in accordance with § 433.153.

(c) To the recipient, any remaining amount. This amount must be treated as income or resources under Part 435 or Part 436 of this subchapter, as appropriate.

(4)

Supreme Court, U.S.
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No. 04-1506

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v.

HEIDI AHLBORN,

Respondent.

On Writ Of Certiorari to the United States Court of Appeals for the Eighth Circuit

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BRIEF OF THE ASSOCIATION OF TRIAL LAWYERS OF AMERICA AS AMICUS CURIAE IN SUPPORT OF RESPONDENTS

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TABLE OF CONTENTS

TABLE OF CONTENTS i

TABLE OF AUTHORITIES ii

IDENTITY AND INTEREST OF *AMICUS CURIAE* 1

SUMMARY OF ARGUMENT 3

ARGUMENT 5

I. Petitioner's Claim of Priority in Reimbursement Is Not Supported by the Statutory Language of the Medicaid Act. 5

II. Petitioner's Claim of Priority in Reimbursement Is Inconsistent With the Public Interest in Efficient Resolution of Legal Disputes. 9

III. Petitioner's Claim of Priority in Reimbursement Would Not Further the Legislative Purpose of Reducing Medicaid's Costs. 14

IV. A Rule of Equitable Apportionment of Settlement Proceeds Would Conform to the Language of the Medicaid Act, Promote Judicial Economy, And Increase Medicaid's Third Party Liability Reimbursements. 19

CONCLUSION 24

TABLE OF AUTHORITIES

Cases

Adams Fruit Co. v. Barrett, 494 U.S. 638 (1990) 9

Agency Holding Corp. v. Malley-Duff & Associates, Inc., 483 U.S. 143 (1987) 18

Ahlborn v. Arkansas Dept. of Human Services, 397 F.3d 620 (8th Cir. 2005) 8

Alyeska Pipeline Service Co. v. Wilderness Society, 421 U.S. 240 (1975) 18

Amadeo v. Zant, 486 U.S. 214 (1988) 9

Asahi Metal Industry Co., Ltd. v. Superior Court of California, Solano County, 480 U.S. 102 (1987) 10

Atteberry v. Memorial-Hermann Healthcare Systems ex rel. Atteberry, 405 F.3d 344 (5th Cir. 2005); 13

Bank of Hamilton v. Dudley's Lessee, 27 U.S. 492 (1829) 9

E.E.O.C. v. Waffle House, Inc., 534 U.S. 279 (2002) 10

Evans v. Jeff D., 475 U.S. 717 (1986) 13

Henning v. Wineman, 306 N.W.2d 550 (Minn. 1981) 21

Hines v. Anchor Motor Freight, Inc., 424 U.S. 554 (1976) 10

In re California Dep't of Health Servs., Dec. No. 1504 (HHS Jan. 5, 1995) 20

Independent Federation of Flight Attendants v. Zipes, 491 U.S. 754 (1989) 13

Loper v. Beto, 405 U.S. 473 (1972) 9

Martin ex rel. Hoff v. City of Rochester, 642 N.W.2d 1 (Minn. 2002), *cert. denied sub nom., Minnesota v. Martin*, 539 U.S. 957 (2003) 21

McDermott, Inc. v. AmClyde, 511 U.S. 202 (1994) 10

Newman v. Piggie Park Enterprises, Inc., 390 U.S. 400 (1968) 18

Pinto v. Aberthaw Const. Co., 637 N.E.2d 219 (Mass. 1994) 13

Rimes v. State Farm Mutual Automobile Ins. Co., 316 N.W.2d 348 (Wisc. 1982) 21

Rotella v. Wood, 528 U.S. 549 (2000) 18

Scripps-Howard Radio v. Federal Communications Comm., 316 U.S. 4 (1943) 18

Texas State Teachers Ass'n v. Garland Independent School Dist., 489 U.S. 782 (1989) 18

United States ex rel. Marcus v. Hess, 317 U.S. 537 (1943) 18

United States v. Winstar Corp., 518 U.S. 839 (1996) 9

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Wilson v. State, 10 P.3d 1061 (Wash. 2000), *cert. denied*, 532 U.S. 1020 (2001) 6

World-Wide Volkswagen Corp. v. Woodson, 444 U.S. 286 (1980) 10

Youngstown Sheet & Tube Co. v. Sawyer, 343 U.S. 579 (1952) 9

Statutes

42 U.S.C. § 1395y 2

42 U.S.C. § 1396a(a) 5, 6, 22

42 U.S.C. § 1396k(a) 5, 6, 7, 22

42 U.S.C. § 1396k(b) 7

42 U.S.C. § 1396p(a) 6, 22

42 U.S.C. §§ 2651-53 2

Ark. Code Ann. § 20-77-302 12

Ark. Code Ann. § 20-77-303 15

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BRIEF OF THE ASSOCIATION OF TRIAL LAWYERS OF AMERICA AS AMICUS CURIAE IN SUPPORT OF RESPONDENTS

IDENTITY AND INTEREST OF *AMICUS CURIAE*

The Association of Trial Lawyers of America ("ATLA") respectfully submits this brief as *amicus curiae.*[1] The parties have filed letters of consent to the filing of this brief with the Clerk of the Court.

[1] Pursuant to Rule 37.6, Amicus discloses that no counsel for a party authored any part of this brief, nor did

ATLA is a voluntary national bar association whose approximately 50,000 members primarily represent individual plaintiffs in civil actions brought under state tort law. Many of the injured plaintiffs represented by ATLA members have received or will receive medical treatment for their injuries paid for by Medicaid.[2] As a result, ATLA members and their clients are directly affected by the construction of statutory provisions in the federal Medicaid Act concerning repayment of medical expenses to state Medicaid agencies out of proceeds obtained from liable third parties through litigation.

ATLA is concerned that the position advocated by petitioner and the United States in this matter would have seriously adverse consequences for persons injured by tortious misconduct. If, as petitioner asserts, state Medicaid agencies are entitled to full repayment of medical expenses out of all litigation proceeds—before any funds go to the injured plaintiffs, and even when a claim is compromised and settled—many plaintiffs will have no incentive to pursue valid claims, thereby allowing

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any person or entity other than Amicus Curiae, its members, or its counsel make a monetary contribution to the preparation or submission of this brief.

[2] Many others have received or will receive medical treatment paid for by some other federal health care program. Although the present case concerns only Medicaid, very similar issues of third party liability and repayment arise under other federal health care programs, including Medicare and health care programs for servicemen and veterans. *See* Medicare Secondary Payer Act, 42 U.S.C. § 1395y; Medical Care Recovery Act, 42 U.S.C. §§ 2651-53.

their tortfeasors to escape responsibility, while many other plaintiffs will have little financial incentive to accept otherwise reasonable settlement offers and thus will be compelled to press their claims to trial, thereby burdening our courts. By contrast, the rule adopted by the Court of Appeals below, which allows for the equitable allocation of limited settlement recoveries between damages for medical expenses—which may be paid by and, to that extent, reimbursable to state Medicaid agencies—and other damages unrelated to medical treatment, is not only fair both to injured plaintiffs and to Medicaid; this rule also will serve the interests of justice, promote the efficient resolution of legal disputes and, in all likelihood, increase the amount of third party liability payments recouped by Medicaid.

SUMMARY OF ARGUMENT

Each year, hundreds of thousands of lawsuits are initiated across the country seeking compensation for injuries caused by tortious conduct. The vast majority of these lawsuits are eventually resolved by settlement, often for less than the full value of the damages suffered by the plaintiffs. *See* Mark Galanter, *The Hundred-Year Decline of Trials and the Thirty Years War*, 57 Stan. L. Rev. 1255, 1272-74 (2005). There are many reasons why a tort plaintiff may decide to settle a case for less than full value: *e.g.*, the inherent risk of litigation, the increased cost of taking a case to trial, problems of proof, a potential finding of contributory or comparative negligence, and limitations on the defendant's ability to pay full compensation. Most plaintiffs and their counsel recognize and accept these inherent limitations on their ability to obtain a complete recovery.

Petitioner, the Arkansas Department of Health and Human Services ("DHHS"), contends that it should be immune from these litigation uncertainties whenever it seeks to obtain reimbursement for medical expenses paid by Medicaid from a potentially liable third-party tortfeasor. In petitioner's view, its claim for reimbursement should take priority over an injured plaintiff's claim against the same tortfeasor for any other category of damages, including loss of past wages and of future earning capacity, permanent disability, pain and suffering, and past and future medical expenses not covered by Medicaid. Accordingly, petitioner insists that, when a tort claim is settled for less than full value, the state Medicaid agency must be reimbursed in full before any recovery can go to the injured plaintiff.

Amicus respectfully submits that this Court should reject petitioner's demands. There are three reasons why. First, DHHS's argument is not supported by the language of the Medicaid Act. Second, its position would significantly impede the efficient resolution of judicial proceedings. Finally, petitioner's proposed scheme would likely diminish Medicaid's overall third-party liability recoveries, and thus is inconsistent with Congress' goal of reducing Medicaid's net costs. By contrast, a rule of equitable apportionment of settlement proceeds among all claimants, including the state Medicaid agency, would be consistent with the statutory scheme, would promote judicial economy, and would likely increase Medicaid's third-party liability reimbursements.

ARGUMENT

I. Petitioner's Claim of Priority in Reimbursement Is Not Supported by the Statutory Language of the Medicaid Act.

The statutory language of the Medicaid Act does not support DHHS's contention that a state Medicaid agency's claim for reimbursement must take priority over an injured plaintiff's claims for compensation for her injuries. To be sure, as petitioner maintains, the third-party liability provisions of the Act clearly make Medicaid's responsibility to pay for a plaintiff's medical treatment secondary to that of the defendant tortfeasor. Significantly, however, the Act says nothing about the relative priority of the state Medicaid agency's claim for reimbursement of medical expenses and the injured plaintiff's claims for other types of damages.

The Act requires the state Medicaid agency, in cases where a third party is liable for the cost of medical assistance paid by Medicaid, "to *seek* reimbursement for such assistance to the extent of such legal liability." 42 U.S.C. § 1396a(a)(25)(B) (emphasis added). To facilitate that effort, the Act declares that the state Medicaid agency "is considered to have acquired the rights of [the Medicaid recipient] to payment by any other party *for such health care items or services,*" 42 U.S.C. § 1396a(a)(25)(H), and further requires the recipient to assign to the state agency his or her "right to payment *for medical care* from any third party," 42 U.S.C. § 1396k(a)(1)(A), and "to cooperate . . . in *pursuing*[] any third party who may be liable to pay

for care and services available under the plan." 42 U.S.C. § 1396k(a)(1)(C) (emphases added).

The Medicaid Act does not require that the state Medicaid agency obtain full reimbursement of its medical expenses from the third party—which in many cases might prove to be difficult or impossible—but merely that the agency "pursue" the potentially liable third party and "seek" reimbursement.[3] Moreover, the state agency does not acquire any rights to any portion of the injured plaintiff's tort claims other than the claim for reimbursement of medical expenses paid by Medicaid. *See Wilson v. State*, 10 P.3d 1061, 1069 (Wash. 2000), *cert. denied*, 532 U.S. 1020 (2001) (Alexander, J., joined by Johnson, Sanders, and Ireland, JJ., dissenting) ("plain language in 42 U.S.C. § 1396a(a)(25)(H) . . . limits a state from acquiring any part of the recipient's recovery from a third party beyond the payment 'for such health care and services'"). The claims for damages unrelated to medical treatment remain the property of the injured plaintiff, who may seek her own recovery from the tortfeasor. Indeed, the Medicaid Act itself shields any recovery for other items of damage from the state Medicaid agency—at least during the life of the Medicaid recipient—by prohibiting the state agency from placing a lien on those proceeds. 42 U.S.C. § 1396p(a)(1).

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[3] The United States, as *amicus curiae*, confirms this, explaining that "[w]here the State is notified and given an opportunity to participate in settlement negotiations, it may compromise its claim in appropriate circumstances . . . ." Brief for the United States at 13.

Most importantly, nothing in the text of the Act grants the state Medicaid agency's right to repayment from the third-party tortfeasor any priority over the injured plaintiff's right to recover for other types of damage.[4] Such legislative silence speaks volumes about the injured plaintiff's right to retain an equitable portion of any recovery.[5]

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[4] Petitioner and its *amici* attempt to wring some textual support for their position out of a statutory provision that is wholly inapplicable to the situation before the Court, 42 U.S.C. § 1396k(b). *See* Petitioner's Brief at 13; Brief for the United States at 12-13. That provision relates to amounts collected by the state Medicaid agency through litigation it initiates pursuant to the Medicaid recipient's assignment of rights to third-party payments under 42 U.S.C. § 1396k(a)(1)(A). Because such an assignment is limited to "payment for medical care from any third party," *id.*, it is not surprising that the Act permits the state agency to retain amounts collected pursuant to the assignment up to the level required for full reimbursement of medical assistance payments. 42 U.S.C. § 1396k(b). But that section says nothing about the state agency's right to lay claim to amounts recovered for types of damages other than medical expenses, especially through cases brought by the injured plaintiff herself.

[5] Indeed, in most states, it is the claims of an injured plaintiff that take priority over the subrogated claims of an entity that paid for the plaintiff's medical care. Under the "made whole" doctrine, a health insurer may not obtain reimbursement for medical payments from a third-party tortfeasor until the injured plaintiff has been fully compensated for his damages. *See* Johnny C. Parker, *The Made Whole Doctrine: Unraveling the Enigma Wrapped in the Mystery of Insurance Subrogation*, 70 Mo. L. Rev. 723, 738-73 (2005)(34 states have adopted the made whole doctrine by statute or court decision).

Reading the third-party liability provisions of the Act in conjunction, and in harmony, with its anti-lien provision leads inexorably to the conclusion reached by the court below.

Unable to find any support in the text of the Act, DHHS and its *amici* attempt to make much of the statement found in a 1985 Senate Report to legislation modifying Medicaid's third-party liability provisions that Medicaid "is intended to be the payer of last resort." S. Rep. No. 99-146 at 279 (1985), *reprinted in* 1986 U.S.C.C.A.N. 42, 312. But this brief expression of legislative intent says nothing more than the statute itself: Medicaid shall not be obliged to pay for medical expenses for which payment can be obtained from a liable third party. The Senate Report does not say that the injured Medicaid recipient must repay the state Medicaid agency its medical expenses out of settlement funds received in compensation for other items of damages, nor does the report suggest that a potentially liable third party must satisfy the state Medicaid agency in full prior to offering any compensation to the injured plaintiff.[6]

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[6] DHHS and its *amici* also rely heavily on both formal and informal interpretations of the third party liability provisions of the Medicaid Act by the U.S. Department of Health and Human Services. These agency rulings should be entitled to no deference by this Court, for several reasons. First, as the court below concluded, these administrative rulings are flatly inconsistent with the text of the act, which nowhere grants priority to a state Medicaid agency's claim for reimbursement. *Ahlborn v. Arkansas Dept. of Human Services*, 397 F.3d 620, 626 (8th Cir. 2005), Pet. App. 1, 11. Second, because these agency interpretations involve only

II. Petitioner's Claim of Priority in Reimbursement Is Inconsistent With the Public Interest in Efficient Resolution of Legal Disputes.

Petitioner's claim of priority in reimbursement is not just inconsistent with the statutory language and legislative history of the Medicaid Act; it also poses serious problems for the administration of justice. Most significantly, it would discourage settlements and impede the efficient resolution of legal disputes.

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a straightforward issue of statutory construction and do not involve any particular area of agency expertise, courts are fully capable of rendering their own independent interpretations of the act. Indeed, as Chief Justice Marshall noted nearly two centuries ago, "[t]he judicial department of every government is the rightful expositor of its laws." *Bank of Hamilton v. Dudley's Lessee*, 27 U.S. 492, 524 (1829). *See Adams Fruit Co. v. Barrett*, 494 U.S. 638, 649-50 (1990).

Finally, and perhaps most significantly, the HHS interpretations at issue can and should be disregarded as entirely self-serving; they construe the statute so as to award the greater share of any tort settlement to that entity (the state Medicaid agency) that will, in turn, return a significant portion of the settlement back to HHS. *See United States v. Winstar Corp.*, 518 U.S. 839, 898 (1996)("The greater the Government's self-interest, however, the more suspect becomes" its arguments). *See Amadeo v. Zant*, 486 U.S. 214, 227 (1988); *Loper v. Beto*, 405 U.S. 473, 502 (1972)(Rehnquist, J., joined by Burger, C.J., Blackmun, & Powell, JJ., dissenting); *Youngstown Sheet & Tube Co. v. Sawyer*, 343 U.S. 579, 647 (1952)(Jackson, J., concurring).

This Court has long recognized a strong public interest in the expeditious resolution of lawsuits through settlement. *See, e.g., Hines v. Anchor Motor Freight, Inc.*, 424 U.S. 554, 574 (1976)(recognizing "the consistent policy of this Court [to] encourag[e] the parties to settle their differences"); *McDermott, Inc. v. AmClyde*, 511 U.S. 202, 215 (1994)("public policy wisely encourages settlements"). Our state and federal judicial systems would cease to function if all, or even a substantial portion, of cases were litigated to trial. Thus, judges and litigants, as well as the public at large, have a strong "interest in obtaining the most efficient resolution of controversies." *World-Wide Volkswagen Corp. v. Woodson*, 444 U.S. 286, 292 (1980). *See also E.E.O.C. v. Waffle House, Inc.*, 534 U.S. 279, 312 (2002); *Volt Information Sciences, Inc. v. Board of Trustees of Leland Stanford Junior University*, 489 U.S. 468, 478 (1989); *Asahi Metal Industry Co., Ltd. v. Superior Court of California, Solano County*, 480 U.S. 102, 115 (1987).

Petitioner's proposed rule is flatly inconsistent with this public interest. If this Court were to rule for petitioner, an injured plaintiff who had received medical treatment funded by Medicaid would have little incentive to settle her personal injury lawsuit for an amount that fell far short of her total claim for damages, because any settlement award immediately would be reduced by the total amount claimed by the state Medicaid agency for reimbursement of medical expenses paid. In addition, the plaintiff would be obliged to pay her attorneys' fees and costs. Only the remainder would belong to the injured plaintiff. Where the cost of treatment funded by Medicaid was substantial, there would be relatively little, if any, money left to compensate plaintiff for her injuries.

Under this scenario, all of the costs and risks of litigation, and all of the uncertainty about potential recovery, would be borne by the plaintiff. The state Medicaid agency would bear none of this risk, and none of these costs, while obtaining a full recovery.

These settlement problems may be further exacerbated under certain circumstances. If the state Medicaid agency is slow or reluctant to reveal the amount of its reimbursement claim, plaintiff will confront even greater uncertainty about the likely size of her personal recovery.[7] Similarly, if the state Medicaid agency is unwilling to bear its proportionate share of attorneys' fees and litigation costs, the plaintiff's potential recovery from any settlement would shrink substantially.[8]

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[7] Although Ms. Ahlborn does not appear to have experienced any difficulty in this case in obtaining information from DHHS regarding the amount of its claimed lien, such is not always the case. Counsel for *amicus curiae* has received letters from many ATLA members attesting to their frequent difficulty in obtaining lien figures for their clients' claims from federal and state health care agencies. The federal Medicare program and its contractors are notorious for refusing to provide information regarding claimed lien amounts until after a tort claim has been settled. (These letters are on file with counsel and can be made available to the Court upon request.) Under these circumstances, plaintiffs are forced to bear not only the uncertainty of litigation, but also substantial uncertainty about the amount of any recovery that may be claimed by the government for reimbursement of medical costs.

[8] It is unclear to *amicus* whether most state Medicaid agencies are willing to share in plaintiff's costs

For these reasons, plaintiffs with substantial Medicaid reimbursement claims will have strong incentives not to compromise their claims through settlement, but instead to "roll the dice" in hopes of obtaining a sufficient recovery through trial. As a hypothetical, imagine a plaintiff with a tort claim potentially worth $400,000, with one half comprised of medical expenses paid by the state Medicaid agency. The defendant offers a settlement of $200,000. If the plaintiff and the state were to share equitably in such a settlement, the plaintiff would be contemplating a recovery of $100,000 less attorneys' fees, along with repayment to the state agency of half

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of obtaining a recovery through litigation. According to the Brief of the United States, the Secretary of Health and Human Services "allows for deduction of the costs of obtaining the award, including attorneys' fees, before reimbursement of the Medicaid program." Brief of the United States at 3, n.2. But it is unclear whether most states reduce their claim for reimbursement by a proportionate share of the litigation costs or simply allow those costs to be paid first, without any reduction in the Medicaid reimbursement if sufficient funds exist. For example, the relevant Arkansas statute seems to require full repayment of DHHS. *See* Petitioner's Brief at 13, n.7; Ark. Code Ann. § 20-77-302 ("In the event of judgment or award in a suit or claim against a third party, if the action or claim is prosecuted by the recipient alone, the court or agency shall first order paid from any judgment or award the reasonable litigation expenses and attorney's fees. After the payment of these expenses and attorney's fees, the court or agency shall order that the Department of Human Services receive an amount sufficient to reimburse the department *the full amount of benefits paid* on behalf of the recipient under the medical assistance program. The remainder shall be awarded to the medical assistance recipient.") (emphasis added).

its outlay for medical expenses. But if, as DHHS insists, the state agency is entitled to full reimbursement, then the plaintiff would take nothing from the proposed settlement. Plaintiff would have virtually no incentive to agree to the settlement offer.[9] The plaintiff would presumably pursue the lawsuit to trial, at substantially greater expense to both the parties and the judicial system, and at the risk of an adverse verdict that would deprive both plaintiff and the state Medicaid agency of any recovery at all.[10]

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[9] A number of decisions by this and other Courts recognize that litigants evaluate settlement offers on the basis of such economic self-interest. *Compare Evans v. Jeff D.*, 475 U.S. 717, 734, n. 23 (1986) (a party "incentive to settle would be diminished because of the risk that attorney's fees, when added to the original merits offer, will exceed the discounted value of the expected judgment plus litigation costs."); *Independent Federation of Flight Attendants v. Zipes*, 491 U.S. 754, 769 (1989)(Blackmun, J., concurring)(a party "has little incentive to make a similar calculation for elements of the settlement package that burden only third parties."); *Atteberry v. Memorial-Hermann Healthcare Systems ex rel. Atteberry*, 405 F.3d 344, 350 (5th Cir. 2005); *Pinto v. Aberthaw Const. Co.*, 637 N.E.2d 219, 223 (Mass. 1994)(once a party realizes that additional litigation or negotiations will not benefit his own interests but merely that of third-parties, "it may have little or no incentive to continue the litigation to secure a larger settlement or verdict.").

[10] Counsel for *amicus curiae* have on file letters from ATLA members providing anecdotal evidence of cases in which this occurred: a settlement offer equal to or less than the Medicaid lien, a decision to pursue the matter to trial, and a defense verdict resulting in no recovery by either the plaintiff or the state Medicaid agency. Copies

Thus, under the petitioner's proposed rule, many more tort lawsuits will proceed to trial, at substantial cost to the administration of justice. This Court should reject a statutory construction of the Medicaid Act that will so interfere with the expeditious resolution of legal disputes.

III. Petitioner's Claim of Priority in Reimbursement Would Not Further the Legislative Purpose of Reducing Medicaid's Costs.

DHHS's proposed rule is not only incompatible with the public interest in judicial economy, it is also likely to undermine rather than advance the Act's explicit legislative purpose of reducing Medicaid's costs. This perhaps counterintuitive conclusion results from the fact that a rule requiring complete reimbursement of the state Medicaid agency's expenses before any recovery by the injured plaintiff will discourage many plaintiffs from pursuing tort claims for their injuries. And, as the United States acknowledges in its brief, private litigation by an injured plaintiff has distinct advantages over independent litigation by the state Medicaid agency as a means for maximizing the total funds recovered. Brief for the United States at 16-17.

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of these letters can be made available to the Court upon request.

It is also possible that, if the case goes to trial, the court may award the state Medicaid agency less than the full medical expenses incurred by Medicaid. Under these circumstances, the Secretary of HHS ordinarily accepts this determination as controlling. *See* Brief for the United States at 22, n.14.

Under petitioner's proposed rule, a seriously injured tort victim with significant medical expenses paid by Medicaid would have to think twice before proceeding with litigation. Prospective counsel would feel obliged to advise her that any recovery she obtained would be reduced by full reimbursement to the state agency, as well as by the payment of attorneys' fees and costs. If there are substantial doubts about the likelihood of success in the litigation—either because of the risk of an adverse verdict or due to concerns about the defendant's ability to pay damages—the tort victim and her counsel might well conclude that the potential reward is not worth the time, effort, and expense of pursuing litigation.

Even if the injured tort victim is willing to proceed with a suit for damages, she may experience difficulties in obtaining competent counsel on a contingency fee basis. Counsel may well be unwilling to represent a client if that client is unlikely to realize any recovery after repayment of a Medicaid lien, regardless of the merits of the litigation. This will be especially true in circumstances where counsel's fee is likely to be based solely on the recovery actually obtained by the plaintiff, not the total damages paid by the defendant(s). For example, Arkansas law provides that, where an injured plaintiff and the state Medicaid agency jointly litigate a third-party liability claim, plaintiff's counsel shall only be entitled to "reasonable attorney's fees based solely on the services rendered for the benefit of the recipient." Ark. Code Ann. § 20-77-303. That is to say, under such circumstances, a plaintiff's counsel is not entitled to any compensation based on the state Medicaid agency's recovery, even though that

recovery could significantly limit the funds available to compensate the plaintiff for her non-medical injuries.[11]

Counsel for *amicus* has received letters from ATLA members attesting to both of these situations. A number of these letters describe prospective clients who decided not to pursue meritorious tort claims after counsel explained the potential effect of a Medicaid lien on their possible recovery. Many more letters describe counsels' own reluctance or refusal to represent plaintiffs in cases involving government medical liens.[12]

But there is far more than anecdotal evidence to demonstrate that a rule granting priority to Medicaid reimbursement out of tort settlements does not effectively advance the government's goal of minimizing Medicaid outlays. One need only look to

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[11] Even in situations in which an attorneys' contingency fee may be calculated on the total recovery, an attorney may be reluctant to take on a plaintiff's claim because of the potentially awkward situation that might result. If the case results in a substantial recovery, most of which will go to the state Medicaid agency, the attorney could find him or herself faced with a client whose recovery is far smaller than the contingency fee. Although such a result may not be unethical, given the attorney's effective representation of both the injured plaintiff and the state agency, it would make many plaintiffs' attorneys uncomfortable. Rather than undertake a lengthy disclosure to a potential client about the potential complexities of this situation, many attorneys may simply opt to decline representation.

[12] All of these letters are on file with counsel and can be provided to the Court upon request.

the figures in the briefs of the *amici* supporting petitioner. In 2004, the Medicaid program expended a total of approximately $309 billion on medical care for indigent persons. *See* National Association of State Budget Officers ["NASBO"], *2003 State Expenditure Report*, at 47, *available at* http://www.nasbo.org/Publications/PDFs/2003ExpendReport.pdf; *see also* Kaiser Commission on Medicaid and the Uninsured, *The Continuing Medicaid Budget Challenge: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2004 and 2005*, at 7, *available at* http://www.kff.org/medicaid/7190.cfm ("For FY 2004, total Medicaid expenditures will exceed $300 billion"). The Secretary of Health and Human Services estimates that "approximately 17% of all Medicaid beneficiaries have some form of third-party coverage for their medical expenses," Brief of the United States at 11, n.5, which would amount to around $52.5 billion. Yet, according to the brief of the United States, in 2004 Medicaid recovered only $1.6 billion nationwide in third party liability payments. Brief of the United States at 1. This amounts to far less than one percent of Medicaid's total outlays for indigent medical care, and barely three percent of the sum the government estimates is subject to third-party liability reimbursement.[13]

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[13] The data in the *amicus* brief submitted on behalf of 29 states and the District of Columbia leads to a similar—but even more stark—conclusion. The appendix to that brief provides information on the amount of third-party liability payments recovered by 26 states in the most recent year for which data is available. Brief of the State of Washington, *et al.* as *amici curiae*, at 1a-3a (some figures are estimates). The 26 states reported annual recoveries totaling about $142 million. By comparison, these same 26 states had total estimated Medicaid

By contrast, it is reasonable to assume that, if tort victims were given an appropriate incentive to seek recovery of the cost of their medical treatment along with compensation for their other injuries, Medicaid's third-party liability recoveries would grow significantly. In any number of other areas of law the government provides such incentives and empowers plaintiffs as private attorneys general to seek redress for wrongs committed against the public.[14] Thus, there is every reason to believe that a

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expenditures in FY 2004 exceeding *$125 billion*. NASBO, *2003 State Expenditure Report*, *supra*, Table 28, p.49. Thus, these states recouped barely one-tenth of one percent of their Medicaid expenditures through third-party liability reimbursement, significantly less than one percent of the amount the Secretary of HHS believes is potentially subject to recoupment. This data confirms that a rule requiring full reimbursement to the state agency prior to any recovery by the tort victim leads to recovery of only a tiny fraction of Medicaid expenditures.

[14] *See, e.g. Rotella v. Wood*, 528 U.S. 549, 557 (2000) ("[t]he object of civil RICO is thus not merely to compensate victims but to turn them into prosecutors, 'private attorneys general,' dedicated to eliminating racketeering activity.") (footnote omitted); *see also Alyeska Pipeline Service Co. v. Wilderness Society*, 421 U.S. 240, 262-64 (1975)(environmental law); *Agency Holding Corp. v. Malley-Duff & Associates, Inc.*, 483 U.S. 143, 151 (1987)(antitrust); *Newman v. Piggie Park Enterprises, Inc.*, 390 U.S. 400, 402 (1968) (per curiam)(civil rights); *Texas State Teachers Ass'n v. Garland Independent School Dist.*, 489 U.S. 782, 793 (1989)(First Amendment rights of public employees); *United States ex rel. Marcus v. Hess*, 317 U.S. 537, 546 (1943)(qui tam); *Scripps-Howard Radio v. Federal Communications Comm.*, 316 U.S. 4, 14 (1943)(communications law).

rule similar to that adopted by the Eighth Circuit, by increasing the possibility that injured plaintiffs would receive some compensation for their injuries, would increase Medicaid reimbursements and further the statutory purpose of reducing Medicaid costs.

IV. A Rule of Equitable Apportionment of Settlement Proceeds Would Conform to the Language of the Medicaid Act, Promote Judicial Economy, And Increase Medicaid's Third Party Liability Reimbursements.

Amicus urges this Court to construe the Medicaid Act in a manner similar to the construction adopted by the court below, and to provide guidance to state and federal courts on the proper application of the law to personal injury settlements. Specifically, *amicus* proposes that any settlement of a tort claim involving a Medicaid lien be equitably apportioned between various claimants and among various items of claimed damages.[15] In most cases, each claimant would be entitled to a share of the settlement equal to its share of the total damages reasonably claimed in the case. Such a statutory construction would fully conform to the statutory language of the Medicaid Act, promote the efficient resolution of judicial disputes, likely increase state Medicaid agency's third-party liability

[15] Although not directly at issue in the present case, state Medicaid agencies and other governmental health care providers often seek priority for reimbursement of medical expenses over the claims of claimants other than the injured plaintiff, such as family members who may be entitled to compensation for, e.g., loss of consortium.

reimbursements, and be equitable to all claimants, including the state and federal governments.

Where the parties cannot agree on an equitable division of the settlement proceeds, the trial court should convene a hearing to undertake such a division. All claimants—including those, like the state Medicaid agency, that have acquired their rights by assignment or subrogation—would receive notice of the hearing and an opportunity to be heard on the value of various items of damage in the case and a fair distribution of the funds.[16]

Such a post-settlement allocation hearing would not be unusual. As the Brief for the United States acknowledges, courts may "conduct post-settlement hearings to allocate settlements between taxable and non-taxable income categories." Brief for the United States at 17, n.7 (citing cases). Similarly, a number of states already have well-developed procedures in place for allocating the proceeds from a tort settlement. In Minnesota,[17] for

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[16] The trial court would not be bound by any agreement reached by some but not all parties to allocate settlement funds to particular categories of damages. This should eliminate any concern that the injured plaintiff might seek to "manipulat[e]" a tort award "to prevent the public from being reimbursed." *In re California Dep't of Health Servs.*, Dec. No. 1504 (HHS Jan. 5, 1995), Pet. App. 68, 81.

[17] Prior to the ruling below, Minnesota was the one state in which the state Medicaid agency's right to reimbursement for Medicaid payments was limited to that portion of any personal injury settlement designated for payment of past medical expenses, pursuant to a ruling of the Minnesota Supreme Court. *Martin ex rel. Hoff v. City of Rochester*, 642 N.W.2d 1 (Minn. 2002), *cert.*

example, trial courts can convene a so-called "*Henning* hearing" to allocate settlement proceeds between categories of damages recoverable by a subrogated insurer and non-recoverable damages. *See Henning v. Wineman*, 306 N.W.2d 550 (Minn. 1981). To the same end, the Wisconsin Supreme Court has upheld a trial court's use of a "*Rimes* hearing," a post-settlement "mini-trial" to allocate proceeds. *See Rimes v. State Farm Mutual Automobile Ins. Co.*, 316 N.W.2d 348 (Wisc. 1982).[18]

In the experience of these states, once such a hearing procedure is developed, it is rarely used. Once all of the interested claimants understand the rules that govern the division of settlement proceeds, it is usually possible for them to agree to an allocation without the need for the time and expense of an allocation hearing. *See* Sharon L. Van Dyck & Wilbur W. Fluegel, *Determining "Full Recovery" Under the Minnesota Anti-Subrogation Statute*, Minn. Trial Lawyer Mag. 18 (Winter 1999).

Amicus recognizes, of course, that it would be inappropriate—and beyond the scope of this case—for this Court to establish specific procedures for state court judicial proceedings to allocate settlement proceeds; that is properly a matter for resolution by state courts and legislatures. Nevertheless, we outline these procedures here for two purposes: first, to reassure the Court that there are workable

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denied sub nom., Minnesota v. Martin, 539 U.S. 957 (2003).

[18] Such a settlement allocation hearing can also be utilized to determine the proper apportionment of litigation costs and attorneys' fees, where necessary.

procedures for resolving issues of equitable apportionment that need not burden trial courts with onerous satellite litigation proceedings; second, and perhaps more important, to encourage this Court to articulate standards for equitable allocation of settlement proceeds in cases involving Medicaid in order to guide the orderly development of such procedures in state courts.

A rule of equitable allocation would be entirely consistent with the Medicaid Act. The Medicaid recipient would assign to the state agency his or her "right to payment for medical care from any third party," 42 U.S.C. § 1396k(a)(1)(A), and the state agency would have "acquired the rights of [the Medicaid recipient] to payment by any other party for such health care items or services." 42 U.S.C. § 1396a(a)(25)(h). The equitable allocation hearing would ensure that the state agency received any and all settlement proceeds attributable to "such health care items or services." At the same time, by allowing the plaintiff to retain proceeds attributable to other items of damages, such a procedure would not run afoul of the Act's anti-lien provision. 42 U.S.C. § 1396p(a)(1).[19]

A rule of equitable allocation would also promote the efficient resolution of judicial disputes. A plaintiff would not be deterred from accepting a reasonable settlement offer from defendant(s) out of

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[19] Such a result would be fair and equitable to both parties. It would give priority neither to the claims of the injured plaintiff, as under the made whole doctrine, *see* fn.5, *supra*, nor to the reimbursement claims of the state Medicaid agency, as under the rule proposed by petitioner.

fear that the settlement proceeds would be swallowed up by the state Medicaid agency's claim for reimbursement. Instead, plaintiffs would be in a position to make a rational economic judgment, based on all of the facts and circumstances, about the reasonableness of the offer in light of the value of the claim, the litigation risk, and the resources of the defendant(s). It would likely become standard practice for plaintiff's counsel to consult with the state agency regarding the settlement offer and obtain its agreement to the acceptance and allocation of the offer.

Finally, a rule of equitable allocation would likely increase the recovery of Medicaid funds through third-party liability payments. By ensuring that injured plaintiffs will receive a fair share of any personal injury judgment or settlement, the rule will properly encourage the victims of tortious conduct to seek to recover for their injuries. And it will make it easier for them to retain counsel on a contingency fee basis. More claims will be vigorously pursued, with the result being a likely increase in the total amount recovered, by both tort victims and state Medicaid agencies.

The rule proposed by DHHS would create an inherent conflict between two entities whose interests should be aligned, the injured plaintiff and the state agency that paid for his or her medical care. By contrast, a rule requiring the equitable allocation of settlement proceeds properly affirms the commonality of interest between these parties, and thereby ensures that they can and will work together for the benefit of both.

CONCLUSION

For the foregoing reasons, *amicus curiae* the Association of Trial Lawyers of America urges this Court to affirm the ruling of the Eighth Circuit in this case.

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January 13, 2006

Supreme Court, U.S.
FILED
NOV 23 2005
OFFICE OF THE CLERK

NO. 04-1506

IN THE SUPREME COURT OF THE UNITED STATES

ARKANSAS DEPARTMENT OF HUMAN SERVICES, ET AL.,

Petitioners,

v.

HEIDI AHLBORN,

Respondent.

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

AMICUS CURIAE BRIEF OF THE STATES OF WASHINGTON, ALASKA, ARIZONA, COLORADO, CONNECTICUT, DISTRICT OF COLUMBIA, GEORGIA, HAWAII, IDAHO, ILLINOIS, KANSAS, KENTUCKY, MAINE, MARYLAND, MASSACHUSETTS, MICHIGAN, MISSOURI, MONTANA, NEW HAMPSHIRE, NEW JERSEY, NEW YORK, NORTH DAKOTA, OHIO, OREGON, RHODE ISLAND, SOUTH CAROLINA, SOUTH DAKOTA, UTAH, WISCONSIN, AND WYOMING IN SUPPORT OF PETITIONERS

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QUESTION PRESENTED

Whether federal Medicaid law, which requires that a medical assistance recipient assign to the state any right to payment from a third party who is liable for the recipient's medical expenses and which also prohibits the placement of a pre-death lien upon a recipient's "property", entitles the state to full reimbursement from personal injury settlement proceeds of Medicaid benefits paid on the recipient's behalf, regardless of what portion of the settlement proceeds are designated as compensation for medical care.

TABLE OF CONTENTS

INTEREST OF AMICI 1

ARGUMENT 10

A. The Eighth Circuit Decision Fails To Reconcile Pertinent Statutes 13

B. Legislative History Demonstrates That The Anti-Lien Provision Was Not Intended To Take Precedence Over Third Party Recoveries From Tortfeasors 15

1. Legislative History Of Anti-Lien Provision 15

2. Legislative History Of Third Party Liability Requirements 23

3. This Court Should Honor Congress' Intent And Reconcile The Statutes To Allow States To Continue Their Recovery Practices 26

C. Congressional Policy In An Analogous Context Supports The States' Practices Of Seeking Full Recovery From Medicaid Recipients 27

CONCLUSION 30

Appendix

TABLE OF AUTHORITIES

Cases

Ahlborn v. Arkansas Dep't of Human Servs.
280 F. Supp. 2d 881 (E.D. Ark. 2003) 4, 8, 11, 30

Ahlborn v. Arkansas Dep't of Human Servs.
397 F.3d 620 (8th Cir. 2005) 4, 6, 7, 12

California Dep't of Health Servs.
D.A.B. No. 1504, 1995 WL 66334
(H.H.S. Jan. 5, 1995) 29

Calvanese v. Calvenese
710 N.E.2d 1079 (N.Y. 1999) 9

Coplien v. Dep't of Health & Soc. Servs.
349 N.W.2d 92 (Wis. 1984) 9

Cricchio v. Pennisi
683 N.E.2d 301 (N.Y. 1997) 9

Grey Bear v. State Dep't of Human Servs.
651 N.W.2d 611 (N.D. 2002) 9

Harris v. McRae
448 U.S. 297 (1980) 1

Houghton v. Dep't of Health
57 P.3d 1067 (Utah 2002) 9

John Hancock Mutual Life Ins. Co. v. Harris Trust & Savings Bank
510 U.S. 86 (1993) 14

Martin ex rel. Hoff v. City of Rochester
642 N.W.2d 1 (Minn. 2002) 8, 9, 10

Nacino v. Koller
71 P.3d 417 (Hawaii 2003) 9

Norwest Bank of North Dakota v. Doth
159 F.3d 328 (8th Cir. 1998) 12

Richards v. State Dep't of Cmty. Health
604 S.E.2d 815 (Ga. 2004) 7, 9

Schweiker v. Gray Panthers
453 U.S. 34 (1981) 14

Walker v. District of Columbia
682 A.2d 639 (D.C. 1996) 9

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D.A.B. No. 1561, 1996 WL 157123
(H.H.S. Feb. 7, 1996) 29

Wilson v. State
10 P.3d 1061 (Wash. 2000) 9

Federal Statutes

10 U.S.C. § 1071-1104 27

42 U.S.C. §§ 1396-1396v 1

42 U.S.C. § 1396 9

42 U.S.C. § 1396a(a)(10)(A) 11

42 U.S.C. § 1396a(a)(10)(C) 11, 12

42 U.S.C. § 1396a(a)(25)(B) 2, 5, 13

42 U.S.C. § 1396a(a)(25)(H) 13

42 U.S.C. § 1396a(a)(5) 3

42 U.S.C. § 1396k 13

42 U.S.C. § 1396k(a)(1)(A) 2, 5

42 U.S.C. § 1396k(b) 4

42 U.S.C. § 1396p 13

42 U.S.C. § 1396p(a) 13

42 U.S.C. § 1396p(a)(1) 5, 10

42 U.S.C. § 1396p(b)(1) 13

42 U.S.C. § 2562(b) 28

42 U.S.C. § 2651(a) 28

42 U.S.C. § 2652(c) 29

Pub. L. No. 103-66, § 13612 (Aug. 10, 1993) 25

Pub. L. No. 103-66, § 13622(c) (Aug. 10, 1993) .. 25, 26

Pub. L. No. 86-778, § 601(b) (Sept. 13, 1960) 18

Pub. L. No. 90-248, § 1902(a) (Jan. 2, 1968) 23

Pub. L. No. 90-248, § 229 (Jan. 2, 1968) 23

Pub. L. No. 95-142, § 12(b) (Oct. 25, 1977) 24

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Pub. L. No. 99-272 (Apr. 7, 1986) 24

State Statutes

Alaska Stat. § 47.05.070(b) 3

Ark. Code § 20-77-307(a) 10, 11

Colo. Rev. Stat. § 26-4-403(3) 3

Colo. Rev. Stat. § 26-4-403(4)(a) 4

Minn. Stat. § 256B.042 8

Minn. Stat. § 256B.056 10

Mont. Code § 53-2-612 4

N.Y. Soc. Serv. Law § 104-b 4

S.C. Code § 43-7-440(D) 4

Wash. Rev. Code § 43.20B.050(2) 4

Wash. Rev. Code § 43.20B.060(1) 3

Federal Regulations

42 C.F.R. § 433.10 4

42 C.F.R. § 435.308 12

42 C.F.R. § 435.4 11

Rules

Rule 37.4 1

Legislative Materials

S. Rep. No. 1945 (1962),
reprinted in 1962 U.S.C.C.A.N. 2637 28

S. Rep. No. 86-1856 (1960),
reprinted in 1960 U.S.C.C.A.N. 3608 ..... 16, 17, 19

S. Rep. No. 89-404 (1965),
reprinted in 1965 U.S.C.C.A.N. 1943 20

S. Rep. No. 90-744 (1967),
reprinted in 1967 U.S.C.C.A.N. 2834 ..... 23, 24

S. Rep. No. 97-494 (1982),
reprinted in 1982 U.S.C.C.A.N. 781 ..... 21, 22

S. Rep. No. 99-146 (1985),
reprinted in 1986 U.S.C.C.A.N. 42 24

Other Authorities

Exec. Order No. 11060,
27 Fed. Reg. 10,925 (Nov. 7, 1962)..... 28

INTEREST OF AMICI

Washington and the other amici states have two substantial interests in the issue presented in this case.[1] First, the amici states have an interest in providing medical assistance to their low income residents who do not have other health care coverage. Toward that end, all of them participate in the federal Medicaid program pursuant to Title XIX of the Social Security Act, 42 U.S.C. §§ 1396-1396v. Medicaid is "a cooperative endeavor in which the Federal Government provides financial assistance to participating States to aid them in furnishing health care to needy persons". *Harris v. McRae*, 448 U.S. 297, 308 (1980).

States are not required to participate in the Medicaid program, but a state that chooses to do so must submit a state Medicaid plan meeting the requirements specified in federal law for approval by the Department of Health & Human Services' Centers for Medicare & Medicaid Services (CMS)[2], the federal agency charged with administering the Medicaid program. In addition, a participating state must comply with all mandatory requirements in order to receive the federal reimbursement. Within the parameters outlined in federal law, states have considerable discretion in structuring their Medicaid program, but are subject to ongoing oversight by CMS, which can impose sanctions if it determines

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[1] This brief is submitted by the Attorneys General of the amici states pursuant to Rule 37.4.

[2] Prior to July 2001, CMS was known as the Health Care Financing Administration (HCFA). Some of the cases cited below refer to it by that name.

that a state's Medicaid program is not being administered consistent with the requirements of federal law.

Second, the amici states have an interest in operating their respective Medicaid programs in a cost-effective manner. More specifically, they have an interest in assuring that publicly-funded medical assistance is provided only when there is no other source from which the cost of such assistance can be paid. The federal government shares this interest and requires, as one of the conditions of federal reimbursement under the Medicaid program, that participating states' Medicaid plans include an assurance that state law requires Medicaid recipients assign to the state Medicaid agency the recipient's "rights . . . to payment for medical care from any third party". 42 U.S.C. § 1396k(a)(1)(A).[3] States also are required to assure that they actively pursue recovery of payments from such third parties. 42 U.S.C. § 1396a(a)(25)(B).

All amici states have adopted legislative provisions and established third party recovery

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[3] Third party liability for medical assistance can arise from a variety of circumstances. For example, a child who receives care may have a legally responsible parent whose identity or location was unknown at the time care was provided. Another example would be a person who had private insurance coverage, the existence of which was unknown at the time the medical assistance was provided. However, this case involves recovery of medical assistance costs incurred as the result of tortious conduct of third parties. This brief accordingly focuses exclusively on this category of third party recoveries.

programs to satisfy these requirements.[4] While the details of the various states' statutes vary somewhat, in general they include the following elements:

- Receipt of Medicaid-funded medical care by a recipient results in the automatic assignment to the state Medicaid agency[5] of the recipient's rights to recover the cost of such care from a responsible third party. *See, e.g.*, Wash. Rev. Code § 43.20B.060(1) .
- As assignee/subrogee, the state Medicaid agency has the right to proceed directly against the liable third party for recovery of the Medicaid expenditures. *See, e.g.*, Colo. Rev. Stat. § 26-4-403(3); Alaska Stat. § 47.05.070(b).
- The state Medicaid agency has a lien against the proceeds of any judgment against the third

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[4] The appendix includes a list of the amici states' respective statutes authorizing their state Medicaid agencies to pursue recovery of the cost of medical assistance provided to recipients under circumstances where a third party is liable to pay for the costs of such care. For all but a few of the amicii states, the appendix reflects the amount recovered for medical costs incurred because of tortious conduct of third parties during the most recent fiscal year for which information is available.

[5] One of the statutory requirements for participation in the Medicaid program is that the state must designate a "single State agency to administer or to supervise the administration of the plan". 42 U.S.C. § 1396a(a)(5). Each of the amici states have complied with that requirement. However, the names given to the agency vary among the states. Therefore, in this brief, the "single state agency" will be referred to as the "state Medicaid agency".

party, or any settlement entered into between the recipient and the third party, to the extent of the cost paid by the state Medicaid agency for the medical assistance provided.[6] *See, e.g.*, N.Y. Soc. Serv. Law § 104-b; Mont. Code § 53-2-612.

Pursuant to 42 U.S.C. § 1396k(b), the federal government shares in these recoveries to the extent of its financial contributions to the states' Medicaid program, which means that between fifty and eighty-three percent of the amounts recovered are reimbursed to the federal government.[7]

The decision below adversely affects the states' interests in providing medical assistance to low income citizens in a cost effective manner. In the case at bar, *Ahlborn v. Arkansas Department of Human Services*, 397 F.3d 620 (8th Cir. 2005), the Eighth Circuit reversed the District Court[8] and held that Arkansas could effect a recovery of medical

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[6] Some states' statutes provide that the lien arises automatically upon the provision of the medical assistance. *See, e.g.*, Colo. Rev. Stat. § 26-4-403(4)(a). Others require an affirmative act, such as filing the lien in public records, in order for the lien to be effective. *See, e.g.*, Wash. Rev. Code § 43.20B.050(2). Finally, some of the amici states' statutes do not specifically create a lien on third party recoveries, but do specify that recovery of the full amount of Medicaid expenditures have priority over other claims against any settlement or judgment. *See, e.g.*, S.C. Code § 43-7-440(D).

[7] The amount of federal contribution to a state's Medicaid program varies between fifty and eighty-three percent. 42 C.F.R. § 433.10.

[8] *Ahlborn v. Arkansas Dep't of Human Servs.*, 280 F. Supp. 2d 881 (E.D. Ark. 2003).

assistance only from that portion of a settlement between a Medicaid recipient and the alleged tortfeasor that represented recovery of medical care costs, rather than the entire settlement.

The Eighth Circuit's holding was predicated on the court's conclusion that a state-created lien designed to effectuate the assignment required by 42 U.S.C. § 1396k(a)(1)(A) and comply with the state's obligation under 42 U.S.C. § 1396a(a)(25)(B) cannot be applied to the portion of the settlement intended to compensate the recipient for losses other than the cost of medical care. This is so, according to the Eighth Circuit, because of the language in 42 U.S.C. § 1396p(a)(1), which bars a state from imposing a lien "against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan" (with certain exceptions irrelevant to this case).

If allowed to stand, this interpretation will adversely affect the interests of the amici states in at least two significant ways. First, and most important, the decision below will reduce the amount amici states recover from third party tortfeasors. Because most personal injury claims are settled, often without initiating litigation, it will be the very rare exception that a state will be able to demonstrate that the settlement amount includes full recovery of its Medicaid expenditures on behalf of the injured party. Accordingly, the amounts of recoveries that states are able to obtain will necessarily decline significantly. The reduction in recoveries that results from the Eighth Circuit's decision will in turn reduce the financial resources

available to the states to provide medical assistance to their citizens, or require that states divert their finite resources from other worthwhile public purposes to make up the difference.

The *Ahlborn* case illustrates the extent of reduced recoveries likely to result from the Eighth Circuit's decision. Ms. Ahlborn was injured in an automobile collision and, as a result, incurred significant injuries, the treatment for which was paid by the Arkansas Medicaid program at a cost of $215,645.30. *Ahlborn*, 397 F.3d at 622. She unilaterally reached a settlement with her own uninsured motorist insurance carrier and with the liability insurance carriers for the parties who allegedly were responsible for causing the collision in the total amount of $550,000. The settlement amount was sufficient to reimburse the Arkansas Medicaid agency completely and leave a significant balance to be divided between Ms. Ahlborn and her attorney. Yet, under the holding of the Eighth Circuit, if allowed to stand, Arkansas' Medicaid agency will recover from this settlement or judgment not the amount of its expenditures, but only "to the extent that a settlement or award constitutes payment by the third party for medical expenses incurred by the recipient". *Ahlborn*, 397 F.3d at 625.

Ms. Ahlborn and the Arkansas Medicaid agency reached a stipulation that apportioned $35,581.47 of the $550,000 settlement as "a fair representation of the percentage of the settlement constituting payment by the tortfeasor for past medical care". *Ahlborn*, 397 F.3d at 622. The basis for computing this amount—which represents approximately sixteen-point-five percent of the total

Medicaid expenditure on Ms. Ahlborn's behalf—is not explained in either the Eighth Circuit decision or the District Court decision that preceded it.

Moreover, in this regard, the *Ahlborn* case is almost assuredly the exception, not the rule. In most situations, it will be unlikely that such agreements will easily be reached. As the Georgia Supreme Court observed in announcing a contrary holding, the approach subsequently adopted by the Eighth Circuit "would allow a Medicaid recipient to negotiate a tort settlement structured in such a way so as to reflect no, or minimal, compensation for medical expenses, or to convince a jury to create such structures, and thereby gain a recovery that does not require any significant compensation to the taxpayers who funded [the recipient's] medical care". *Richards v. State Dep't of Cmty. Health*, 604 S.E.2d 815, 818 (Ga. 2004). The Georgia Supreme Court concluded that this "would be blatantly unfair to those taxpayers". *Id.*

The second adverse impact on the amici states is that the decision below will inevitably increase administrative and legal costs that states will have to incur in pursuing third party recoveries. The Eighth Circuit opinion gave minimal significance to the difficulties of determining the proper amount of recovery under its ruling, suggesting that, in an individual case, recovery of more than the amount characterized by the parties as recovery of medical expenses "might be permissible because the third-party payment is properly recharacterized as a payment for medical expenses, despite a different label applied by the parties". *Ahlborn*, 397 F.3d. 627. This case-by-case approach is damaging because the

enormous difficulty of allocating a lump sum settlement among several potential damage components is a practical reality that will result in an inevitable increase in administrative and legal costs that states will have to incur in pursuing third party recoveries.

Under most of the amici states' current practices, the injured Medicaid recipient pursues the recovery from the tortfeasor. When a judgment or settlement has been achieved, the state Medicaid agency is able to assert its lien or statutory priority up to the total amount of the medical assistance provided and is often able to recover the full amount of its expenditures without requiring active intervention in the litigation by its legal counsel. The Eighth Circuit's decision, however, will force states to choose between two undesirable approaches: (1) deferring to the allocation decisions of the parties, who, as the District Court noted, have "no interest in placing an appropriate value on that component of recovery" (*Ahlborn*, 280 F. Supp. 2d at 888), or (2) actively intervening in the litigation in every instance to protect their interest in maximizing recoveries.

The experience of the State of Minnesota is illustrative of both the reduction of recovery from third party tortfeasors and the increase in administrative and legal costs. Information from the Minnesota Medicaid agency indicates that prior to the decision of the Minnesota Supreme Court in *Martin ex rel. Hoff v. City of Rochester*, 642 N.W.2d 1 (Minn. 2002), the agency relied primarily on its statutory lien under Minn. Stat. § 256B.042 to recover Medicaid expenditures from the proceeds of recipients' tort settlements. Pursuant to that

statute, Medicaid recipients were required to notify the department upon any settlement of claims against liable third parties. The department would then apply the formula set forth in the lien statute to determine what portion of the settlement must go to reimburse Medicaid expenditures. This is typical of the manner in which most amici states currently effectuate third party recoveries.

The *Martin* decision altered this process by striking down Minnesota's lien statute on the same basis underlying the Eighth Circuit's decision in the case at bar, i.e., that the Minnesota lien statute impermissibly attached to non-medical claims that the recipient was not required to assign as a condition of Medicaid eligibility under federal law contrary to 42 U.S.C. § 1396p.[9] The *Martin* court also interpreted the assignment statute narrowly—as applicable only to claims or proceeds for medical expenditures. Since *Martin*, Minnesota's Medicaid agency no longer is able to rely on its lien to recover

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[9] Other than the Eighth Circuit below and the *Martin* court, all other appellate courts that have addressed the issue have concluded that application of the state Medicaid agency's lien or other statutory priority to the entire settlement or judgment does not violate the anti-lien statute, because the federally required assignment transfers the entire cause of action to the state. *See Richards v. State Dep't of Cmty. Health*, 604 S.E.2d 815 (Ga. 2004); *Nacino v. Koller*, 71 P.3d 417 (Hawaii 2003); *Houghton v. Dep't of Health*, 57 P.3d 1067 (Utah 2002); *Grey Bear v. State Dep't of Human Servs.*, 651 N.W.2d 611 (N.D. 2002); *Wilson v. State*, 10 P.3d 1061 (Wash. 2000); *Calvanese v. Calvenese*, 710 N.E.2d 1079 (N.Y. 1999); *Cricchio v. Pennisi*, 683 N.E.2d 301 (N.Y. 1997); *Walker v. District of Columbia*, 682 A.2d 639 (D.C. 1996); *Coplien v. Dep't of Health & Soc. Servs.*, 349 N.W.2d 92 (Wis. 1984).

its expenditures from third parties. Instead, it has been required to rely on the statutory assignment of medical claims pursuant to Minn. Stat. § 256B.056 and to take affirmative action to assert this reimbursement right. As a result, since *Martin*, Minnesota has more frequently been required to resolve third party tort actions by accepting less than a full recovery of its Medicaid expenditures.

Minnesota's collection costs have also increased. Since the *Martin* decision, the Minnesota Department of Human Services has referred 776 cases to the Minnesota Attorney General's Office. Of those cases, AG staff have intervened in ongoing litigation in 119 cases, obtained agreements from the recipient's counsel to represent the department in approximately 165 cases, and referred 33 cases to outside counsel for representation, resulting in an increase in the costs of legal representation in third party recovery actions the state is pursuing.

ARGUMENT

The anti-lien statute on which the Eighth Circuit decision turned provides that (with exceptions not pertinent here) "[n]o lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan". 42 U.S.C. § 1396p(a)(1). However, under the Arkansas statute, Ms. Ahlborn and other Medicaid recipients assigned their rights to "any settlement, judgment, or award which may be obtained against any third party to [the Arkansas Medicaid agency] to

the full extent of any amount which may be *paid by Medicaid* for the benefit of the applicant". Ark. Code § 20-77-307(a) (emphasis added).

Thus, as the District Court recognized, the only portion of Ms. Ahlborn's claim for reimbursement from the tortfeasor that remained her property was that amount exceeding the amount that Arkansas had paid for her medical care. *Ahlborn*, 280 F. Supp. 2d at 888 (quoting *Wallace v. Estate of Jackson*, 972 P.2d 446, 448 (Utah 1998)). As applied to Ms. Ahlborn, this means that only the difference between the total settlement amount of $550,000 and the Medicaid expenditures of $215,645.30 was her property. The assignment of her rights resulting from the application of the state assignment statue transferred any interest she had in the latter amount to the Arkansas Medicaid agency.

The Eighth Circuit's contrary conclusion fails to reconcile the pertinent statutes and is inconsistent with their legislative history. The anti-lien provision was intended to protect the assets of the aged, blind, and disabled individuals who had sufficient income and resources to meet their basic needs but not enough to pay increasingly higher medical costs.[10] In

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[10] The Medicaid Act generally defines two groups of needy persons that may be included in a state's Medicaid program—the categorically needy and the medically needy. 42 U.S.C. § 1396a(a)(10)(A), (C); 42 C.F.R. § 435.4. Generally speaking, the categorically needy group consists of those persons who, regardless of their age or medical condition, lack sufficient income or resources to meet basic needs, including routine medical care. The medically needy group that a state may choose to cover under Medicaid consists primarily (again,

contrast, the history of third party liability requirements demonstrates that Congress intended to make third parties pay whenever possible so that Medicaid was the payer of last resort. The Eighth Circuit had recognized this strong congressional intent seven years before its *Ahlborn* decision in *Norwest Bank of North Dakota v. Doth*, 159 F.3d 328 (8th Cir. 1998). In rejecting an argument that Minnesota's lien for Medicaid expenditures did not reach settlement proceeds placed in a special needs trust, the Eighth Circuit stated that to hold otherwise "would eviscerate Congress's clearly expressed intention that these funds be repaid and negate the Social Security Act's comprehensive scheme permitting states to place these liens". *Norwest Bank*, 159 F.3d at 333 (internal punctuation omitted).[11]

So strong is this policy that the federal government has sanctioned states for agreeing to accept less than the full amount of Medicaid expenditures from recipients' settlements with third party tortfeasors.

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generally speaking) of those aged, blind, or disabled individuals whose income and resources are sufficient to meet their daily needs, but not sufficient to cover the costs of extraordinary medical expenses, primarily long-term care. 42 U.S.C. § 1396a(a)(10)(C); 42 C.F.R. § 435.308.

[11] The *Norwest Bank* court specifically stated that it was not ruling on "whether the [state's] lien may be satisfied out of the entire amount of the personal injury award or settlement, or only that portion of the settlement attributable to past medical expenses". *Norwest Bank*, 159 F.3d at 334.

A. The Eighth Circuit Decision Fails To Reconcile Pertinent Statutes

The resolution of this case requires this Court to analyze the intersection of three statutes:

- 42 U.S.C. § 1396a(a)(25)(B) and (H), which require states to identify and actively pursue recovery from third party tortfeasors who are liable for medical expenses incurred by Medicaid recipients and to have in effect laws under which the state acquires the recipient's right to recover from a third party;
- 42 U.S.C. § 1396k, which requires states to ensure that Medicaid recipients assign any rights they have to recovery of medical expenses from third parties; and
- 42 U.S.C. § 1396p, which prohibits states from imposing liens "against the property of any individual prior to his death on account of medical assistance" (§ 1396p(a)) (with exceptions not relevant here) and further provides that "[n]o adjustment *or recovery* of any medical assistance correctly paid on behalf of an individual under the State plan may be made" (§ 1396p(b)(1)) (emphasis added).

On the face of these provisions, there appears to be a conflict between § 1396a(a)(25)(B) and (H) and § 1396k—requiring states to secure assignment of rights to recover payment for medical costs and to vigorously pursue such recovery—and § 1396p—prohibiting both imposition of liens against "property" of a recipient and "recovery" of medical

assistance "correctly paid".[12] In resolving seeming conflicts, this Court should "examine first the language of the governing statute, guided not by a single sentence or member of a sentence, but looking to the provisions of the whole law, and to its object and policy". *John Hancock Mutual Life Ins. Co. v. Harris Trust & Savings Bank*, 510 U.S. 86, 94-95 (1993) (internal punctuation omitted).

This is particularly true with respect to the Medicaid provisions of the Social Security Act, which this Court has agreed "is among the most intricate ever drafted by Congress [with a] Byzantine construction [that] makes the Act almost unintelligible to the uninitiated". *Schweiker v. Gray Panthers*, 453 U.S. 34, 43 (1981) (quoting Judge Friendly in *Friedman v. Berger*, 547 F.2d 724, 727 n.7 (2d Cir. 1976)).

The Eighth Circuit did not adopt this Court's approach; rather, it simply held that the state's recovery efforts must yield to the anti-lien provisions without any consideration of either the object or policy of any of the three sections of the Medicaid Act implicated in this case. Had the court below adhered to this Court's guidance quoted above, it would have read the three provisions in a manner that gives maximum effect to, and accomplishes the policy objectives of, each of the three sections.

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[12] In the case at bar, there is no dispute that medical assistance was "correctly paid" on behalf of Ms. Ahlborn.

B. Legislative History Demonstrates That The Anti-Lien Provision Was Not Intended To Take Precedence Over Third Party Recoveries From Tortfeasors

1. Legislative History Of Anti-Lien Provision

The anti-lien provision of the Medicaid Act had its genesis in the 1960 amendments to the Social Security Act that created the predecessor to the Medicaid program. Prior to the enactment of these amendments, the federal government participated financially in programs under which some, but not all, states provided "old age assistance" for needy persons over 65 years of age, i.e., those lacking sufficient income or resources to meet their basic needs. These programs, like Medicaid, were optional with the states. The amount and scope of assistance they provided, and the manner in which it was provided, varied greatly among the states.[13]

The 1960 amendments to the Social Security Act provided an increased level of federal support for the existing old age assistance programs for the needy. In addition, they authorized a new state-federal partnership, known informally as the Kerr-Mills program. Under this program, the federal government offered incentives to states to provide medical assistance to persons over the age of 65 who were not eligible for "old age assistance" because they had sufficient income for their basic needs, but

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[13] For a more detailed outline of the nature of medical assistance provided and the manner in which it was distributed by the various states, see 1960 U.S.C.C.A.N. at 3730-41.

lacked sufficient resources to meet increasingly higher medical care costs. The Senate Finance Committee Report accompanying the legislation explained:

> "The major issue presented to the committee this year has been the increasing cost of adequate medical care for older people. The evidence presented to the committee indicated that these costs derive, to a large extent, from the fact that impressive improvements have been made in medicines and medical technology, which assist in better diagnosis and treatment, and from improved hospital and other facilities and their wider availability to the public. . . .
>
> "As a result, we are recommending a program of federal assistance in providing, through the cooperation of the states, an expanded program of medical care for persons aged 65 and over. Under this proposal the federal share of existing old-age assistance plans will be substantially increased to encourage states to strengthen their medical programs for these people or to initiate new programs. In addition, federal money will be made available, on a generous matching formula, to assist the states in aiding those aged persons, many of them otherwise self-sufficient, who need help only in meeting the cots of medical care of a very expensive nature." S. Rep. No. 86-1856 (1960), *reprinted in* 1960 U.S.C.C.A.N. 3608, 3609.

In addition to the increased federal funding, the legislation was also generous in allowing states to disregard a recipient's resources in determining eligibility. The report describes the changes:

> "Under this program, it will be possible for states to provide medical services to individuals on the basis of an eligibility requirement that is more liberal than that in effect for the States' old-age assistance programs.
>
> ". . . .
>
> "A state may, if it wishes, disregard in whole or in part, the existence of any income or resources, of an individual for medical assistance. . . .
>
> "This is based on the grounds that an aged individual who has adjusted his living standard to a low income, but who still has income and resources above the level applicable for old-age assistance, might be unable to deal with his medical expenses." S. Rep. No. 86-1856 (1960), *reprinted in* 1960 U.S.C.C.A.N. at 3613-14.[14]

As with the current Medicaid Act, those states that chose to participate in the Kerr-Mills program were required to submit a state plan specifying the scope of medical assistance offered and meet certain statutory requirements, which included the following:

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[14] Although not denominated as such, this group is the antecedent to the "medically needy" group of recipients that states have the option to include in their Medicaid programs under current law. *See* note 10 *supra* p. 11-12.

> "*[I]f the State plan includes medical assistance for the aged* [it must] provide that no lien may be imposed against the property of any individual prior to his death on account of medical assistance for the aged paid or to be paid on his behalf under the plan . . . and that there shall be no adjustment or recovery (except, after the death of such individual and his surviving spouse, if any, from such individual's estate) of any medical assistance for the aged correctly paid on behalf of such individual under the plan." Pub. L. No. 86-778, § 601(b) (Sept. 13, 1960) (emphasis added) (adding § 2(a)(11)(E) to the Social Security Act).

The reason for conditioning this requirement on a state's decision to include medical assistance in addition to old-age assistance in its program is apparent from the context. Recipients of old-age assistance for the needy, by definition, had little by way of resources and, thus, had no property against which a state could assert a lien. However, with the expanded coverage to those that, in current Medicaid parlance, would be considered "medically needy", and who may have significant resources, particularly in the form of a residence, a state's incentive to assert such a lien would be greater.

Likewise, the purpose for inserting the anti-lien provision is apparent from the context. Without the foregoing language, elderly couples who owned their own homes would be required to sell them and use the proceeds to pay for their own care before becoming eligible for the new program. The anti-lien

provision was designed to prevent that from occurring, as described in the Senate report.

> "Although the requirements for the approval of the medical assistance for the aged in the state plan are generally comparable to those in the public assistance titles of the Social Security Act, the committee concluded that some changes are needed to carry out the intent of the new part of the program.
>
> "A state would not be permitted as a condition for medical assistance to impose a lien on the property of a recipient during his lifetime. . . . However, the bill would permit the recovery from an individual's estate after the death of his spouse if one survives him. *This provision was inserted in order to protect the individual and his spouse from the loss of their property, usually the home, during their lifetime.*" S. Rep. No. 86-1856 (1960), *reprinted in* 1960 U.S.C.C.A.N. 3608, 3615 (emphasis added).[15]

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[15] In addition to the beneficent aspects of the congressional policy reflected in this provision, allowing elderly couples to retain ownership of their residences during their lifetime also had a desirable practical effect. The contrary approach—de facto requiring an elderly person who needed extensive medical assistance to liquidate his or her residence before receiving any assistance—would, in many instances, create an even greater burden on the social welfare system, as persons needing medical care and others dependent upon them would ultimately come to rely on government support. Allowing recovery of the costs of medical assistance from the estate of the recipient *after* the death of the spouse and any dependent children allowed the family to remain in their home as long as possible, in many instances reducing public

Thus, from the outset, the purpose of the anti-lien statute was focused on recovery from the estates of the elderly who had received medical assistance and had nothing to do with recoveries from third parties of medical assistance provided because of their tortious conduct.

When the Medicaid program was created in 1965, the anti-lien language was retained, and the focus on assistance to the aged remained intact. The report accompanying that legislation explained:

> "[The current provisions of the Social Security Act] authorizing the medical assistance for the aged program now provide that the States may not impose a lien against the property of any individual prior to his death on account of medical assistance payments [with exceptions not pertinent here] and prohibit adjustment or recovery for amounts correctly paid except from the estate of an aged person after his death and that of his surviving spouse. This provision, under the committee bill, has been broadened so that such an adjustment or recovery would be made only at a time when there is no surviving child who is under the age of 21 or who is blind or permanently and totally disabled." S. Rep. No. 89-404 (1965), *reprinted in* 1965 U.S.C.C.A.N. 1943, 2020.

Though the scope of the anti-lien provision was "broadened" to protect a deceased recipient's

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assistance expenditures, and ultimately allowed taxpayers to recover the costs that were incurred.

dependents in addition to the surviving spouse, there is no indication in the legislative record that Congress intended to broaden the purpose of the statutory language beyond that described in the Senate report that described the initial legislation.

Further evidence that the anti-lien statute's focus was on estate recovery from the elderly is demonstrated by the Tax Equity & Fiscal Responsibility Act of 1982 (TEFRA), Pub. L. No. 97-248 (Aug. 19, 1982), which amended the anti-lien provision and the related "look-back" provision which allowed states to deny eligibility for medical assistance to an otherwise eligible applicant who had transferred assets for less than full value during the 24 months preceding the application. Because the Medicaid Act as it existed at the time did not consider an applicant's home as a resource, "an elderly individual who anticipates needing nursing home care [could] give his/her home to a family member or friend without fear of losing or being denied Medicaid eligibility [and] by so doing [assure] that the home will not be part of his/her estate and therefore will not be subject to any recovery action initiated by the state after the individual's death". S. Rep. No. 97-494 (1982), *reprinted in* 1982 U.S.C.C.A.N. 781, 814.

To address this situation, the report explained, the legislation amended Title XIX in two particulars. The first authorized states to deny eligibility to an applicant for Medicaid who had disposed of his or her home. The second effect of the amendment was described as follows:

> "Second, the amendment would allow states to attach the real property, including the home, of Medicaid recipients who are permanently institutionalized in nursing homes or other long term care medical institutions. The lien could not be foreclosed upon, and states could recover the costs of medical assistance provided to the recipient only when the recipient voluntarily chose to sell the property or, after the recipient's death, from his estate. As under current law, no recovery would be permitted while the recipient's spouse was still living or while his/her children were still dependent (under 21, or blind, or disabled)." S. Rep. No. 97-494 (1982), *reprinted in* 1982 U.S.C.C.A.N. 781, 814-15.

The report described the purpose of the amendment as "facilitat[ing] States' efforts to recover medical assistance costs from these types of resources and to assure that all resources available to an individual will be used to defray the public costs of supporting that individual in a long-term medical institution". *Id.* at 815.

There is no suggestion in the legislative history of the anti-lien law that Congress considered the statute would have any application to any context other than that described above. More specifically, there was no indication that Congress perceived a conflict between the anti-lien law and the states' efforts to recover expenditures for medical assistance from third-party tortfeasors.

2. Legislative History Of Third Party Liability Requirements

By contrast, the legislative history of the Medicaid third party liability requirements demonstrates an increasingly strong Congressional policy that recoveries from third parties be maximized, consistent with the maxim that Medicaid is to be the payor of last resort. A requirement that states participating in Medicaid must identify potential third parties who might be liable to pay for the medical assistance provided was first added to the Medicaid Act in 1968. *See* Pub. L. No. 90-248, § 229 (Jan. 2, 1968) (adding new subsection to § 1902(a) of the Social Security Act). The Senate report described this requirement as follows:

> "It is obvious that many people need medical care because of an accident or illness for which someone else has fiscal liability; for example a health insurer or a party who is determined by a court to have legal liability. In order to make certain that the State and the Federal Governments will receive proper reimbursement for medical assistance paid to an eligible person when such third-party liability exists, a new requirement would be included in title XIX. Under this provision, the State or local agency would have to take all reasonable measures to ascertain the legal liabilities of third parties to pay for covered services. Where the legal liability is known it would be treated as a resource of the recipient. In addition, if medical assistance is granted and legal liability of a third party is established later, the State or local agency

> must seek reimbursement from such party. The Federal Government would, of course, recover its share of any reimbursement received." S. Rep. No. 90-744 (1967), *reprinted in* 1967 U.S.C.C.A.N. 2834, 3039.

In 1977, Congress strengthened the ability of states to identify and collect from third parties liable because of tortious conduct, or on some other basis, by granting permission to states to require an assignment by Medicaid recipients of medical support and/or indemnification to the state as a condition of eligibility. *See* Pub. L. No. 95-142, §12(b) (Oct. 25, 1977) (adding new § 1912 to the Social Security Act). This permissive approach was made mandatory in 1984 with the enactment of the Deficit Reduction Act of 1984, Pub. L. No. 98-369, § 2367(a) (July 18, 1984) (adding new subsection to § 1902 of the Social Security Act) and § 2367(b) (amending § 1912(a) of the Social Security Act).

These provisions were strengthened again by the enactment of the Comprehensive Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-272 (Apr. 7, 1986), which added various provisions to enhance states' efforts to recover medical assistance payments made to recipients for which third parties are liable. As the Senate report explained:

> "Medicaid is intended to be the payer of last resort, that is, other available resources must be used before Medicaid pays for the care of an individual enrolled in the Medicaid program." S. Rep. No. 99-146 (1985), *reprinted in* 1986 U.S.C.C.A.N. 42, 279.

In 1993, Congress further amended the section of the Social Security Act that includes the anti-lien provision to mandate that states pursue recoveries from the estates of recipients who were either permanently institutionalized or, after age 55, received "nursing facility services, home and community based services, and related hospital and prescription drug services". Pub. L. No. 103-66, § 13612 (Aug. 10, 1993) (amending § 1917(b)(1) of the Social Security Act). The amendment authorized states to identify in their state plans additional services that would be subject to estate recovery. *Id.*

In the same legislation, Congress amended the third party recovery sections of Title XIX of the Social Security Act to require further strengthening of the states' third party recovery. Specifically, state Medicaid plans must now include the following:

> "[T]o the extent that payment has been made under the State plan for medical assistance in any case where a third party has a legal liability to make payment for such assistance, the State [must have] in effect laws under which, *to the extent that payment has been made* under the State plan for medical assistance . . . furnished to an individual, the State *is considered to have acquired the rights of such individual to payment by any other party* for such health care items or services." Pub. L. No. 103-66, § 13622(c) (Aug. 10, 1993) (emphasis added) (adding subsection (I) to § 1902(a)(25) of the Social Security Act).

There is nothing in these 1993 amendments to the section of the Social Security Act that includes

the anti-lien provision or the sections dealing with third party recoveries that suggest Congress perceived a conflict between the two. Indeed, there is no conflict between the two because both are designed ultimately to achieve the same result, i.e., to enable states to provide medical assistance to qualified recipients and later recover the costs expended from the state and federal treasuries in so doing. The Eighth Circuit's decision concluded that there is a conflict and, in the process of resolving it, eliminated a significant tool used by states to assure that they are "considered to have acquired the rights of such individual to payment by [another] party". Pub. L. No. 103-66, § 13622(c) (Aug. 10, 1993). The decision below is contrary to the congressional policy evident in the Medicaid Act and in its legislative history, and should be reversed.

3. This Court Should Honor Congress' Intent And Reconcile The Statutes To Allow States To Continue Their Recovery Practices

As the legislative history demonstrates, this case lies at the intersection of two strong congressional policies: the first protects the homes of medically needy persons requiring long-term care, yet allows the taxpayers to eventually recover the costs of care from their estates; the second requires states to maximize their recovery of medical assistance necessitated by the tortious conduct of third parties. These policies do not conflict with each other. They share the common theme of minimizing the expenditure of public funds for individual medical care when other resources are or may become available.

The Eighth Circuit's decision frustrates the intent of Congress by limiting the states' recoveries to an amount that, in most cases, will be less than the amount of assistance provided. The District Court's decision—and that of every other court, save one, that have considered the issue—furthers the congressional intent to maximize recoveries without, in any manner, hindering the intent underlying the anti-lien statute. This Court should do likewise by reversing the Court of Appeals and remanding this matter with instructions to affirm the District Court's decision.

C. Congressional Policy In An Analogous Context Supports The States' Practices Of Seeking Full Recovery From Medicaid Recipients

The instant case deals with medical care paid for in part by the federal government and the states' ability to recover both the state and federal portion of the costs incurred in appropriate instances. This is not the only context under which the federal government seeks to recoup the costs of medical care for which it either pays or provides directly.

The federal government provides health care to certain military and civilian personnel and their families. *See, e.g.*, 10 U.S.C. § 1071-1104 (authorizing medical and dental benefits for members of the armed forces and their families). When the necessity for medical care provided by a federal agency arises out of the tortious conduct of a third party, the federal Medical Care Recovery Act (MCRA) gives the federal government a right of action against the tortfeasor for "the reasonable value of the care and

treatment so furnished, to be furnished, paid for, or to be paid for". 42 U.S.C. § 2651(a).

Unlike the Medicaid third party recovery statutes, the MCRA includes an explicit provision authorizing the federal agency to either compromise its claim for recovery of medical costs or waive the claim "in whole or in part" subject to regulations promulgated by the Department of Justice.[16] 42 U.S.C. § 2562(b). As the Senate report that accompanied this legislative enactment to the MCRA explained: "[I]t is not intended that this legislation should be used to recover Federal hospital and medical costs when the total recovery possible is insufficient, under all the circumstances, to provide fair and adequate compensation to the injured person for his own losses". S. Rep. No. 1945 (1962), *reprinted in* 1962 U.S.C.C.A.N. 2637, 2642.

The only condition precedent to a waiver under the MCRA is a determination by the agency head or designee that (1) doing so is in the best interest of the government or (2) that collection of the government's claim "would result in undue hardship upon the person who suffered the injury or disease resulting in care or treatment." 42 U.S.C. § 2562(b). Significantly, also unlike the Medicaid

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[16] The MCRA authorizes the President to promulgate implementing regulations, authority that the President has delegated to the Attorney General. Exec. Order No. 11060, 27 Fed. Reg. 10,925 (Nov. 7, 1962). The regulations may be found at 28 C.F.R. Part 43. Speaking generally, they provide that the agency which provided or paid for the care may compromise or waive any claim that does not exceed $100,000 and require Department of Justice approval for compromise or waiver of claims for larger sums.

third party recovery provisions, the MCRA specifically directs that no actions taken in its enforcement "shall operate to deny to the injured person the recovery for that portion of his damage not covered hereunder". 42 U.S.C. § 2652(c).

Presumably because of the lack of such language in the Medicaid third party recovery provisions, the federal agency responsible for overseeing state Medicaid programs has imposed sanctions against at least two states for having agreed to accept less than the full amount of Medicaid expenditures from recipients' settlements with third party tortfeasors. *California Dep't of Health Servs.*, D.A.B. No. 1504, 1995 WL 66334 (H.H.S. Jan. 5, 1995); *Washington Dep't of Soc. & Health Servs.*, D.A.B. No. 1561, 1996 WL 157123 (H.H.S. Feb. 7, 1996). In both of these cases, the state agencies had done what the MCRA explicitly would have allowed—compromise third party recovery claims for less than the amount of medical costs incurred. In both instances, the Health Care Financing Administration (HCFA), now known as CMS, required the states to reimburse the federal government for the full amount of federal funds that would have been recovered except for the state's compromise, a position that was upheld by the departmental appeals board.[17] This approach was consistent with HCFA policy statements dating back

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[17] In No. 1561, the Department of Health & Human Services Appeals Board upheld the provisions of the Washington statute providing that the state's Medicaid recovery from a settlement or judgment is to be reduced by a pro rata share of the recipient's attorney fees incurred in resolving the claim.

as far as 1988. J.A. at 27-41 (Ex. 3, 21, 22, discussed at *Ahlborn*, 280 F. Supp. 887).

The explicit language of the MCRA and its implementing regulations, together with the legislative history, demonstrate that when Congress wants to authorize the compromise of the recovery of publicly funded medical care, it says so explicitly. The lack of similar language in the Medicaid Act, combined with the strong language mandating full recovery of costs from liable third party tortfeasors, indicates a contrary intent in the Medicaid context.

In short, the Eighth Circuit's decision is inconsistent with the intent underlying the Medicaid Act, as evidenced by the language and legislative history of the pertinent statute and congressional expressions of contrary intent in an analogous context. The decision below should be reversed.

CONCLUSION

For the reasons set forth above, the Court of Appeals decision should be reversed and this matter remanded with directions to affirm the decision of the District Court.

RESPECTFULLY SUBMITTED.

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Appendix

State	Citation To State Statute	Annual Recoveries
Alaska	Alaska Stat. §§ 47.05.070, .075; 47.07.025	$1,356,716 (FY 2002)
Arizona	Ariz. Rev. Stat. Ann. §§ 36-2903(F), -2903.01(K), -2915, -2916; 12-962,	$10 million (estimate)
Colorado	Colo. Rev. Stat. § 26-4-403(3), (4), (5)	$3,072,421.49 (FY 2004-2005)
Connecticut	Conn. Gen. Stat. § 17b-265	$5.9 million (FY 04-05)
District of Columbia	D.C. Code §§ 4-601 to -607	(not available)
Georgia	Ga. Code Ann. §§ 49-4-140, -148(a), -149(a), -149(d), -157	$9,471,778
Hawaii	Haw. Rev. Stat. §§ 346-29(c), -37	$1-3 million (estimate)
Idaho	Idaho Code. Ann. § 56-209b	$1.6 million
Illinois	305 Ill. Comp. Stat. 5/11-22	$15,000,000 (estimate)

State	Citation To State Statute	Annual Recoveries
Kansas	Kan. Stat. Ann. § 39-719a	$1.7 million (estimate)
Kentucky	Ky. Rev. Stat. Ann. §§ 205.520, .624, .626, .628, .629	(not available)
Maine	Me. Rev. Stat. Ann. tit. 22, § 14	$5 million (estimate)
Maryland	Md. Code Ann. Health-Gen. §§ 15-120 to -121.3	(not available)
Massachu-setts	Mass. Gen. Laws ch. 118E, § 22; ch. 18, § 5G; ch. 152, § 46A	$10,685,590.86 (FY 2005)
Michigan	Mich. Comp. Laws § 400.106	$4 million
Missouri	Mo. Rev. Stat. §§ 208.2159, 287.266	$7,236,460.89
Montana	Mont. Code Ann. §§ 53-2-612, -613	$1,727,201 (FY 2004-2005)
New Hampshire	N.H. Rev. Stat. Ann. § 167:14-a	$1,152,313
New Jersey	N.J. Stat. Ann. §§ 30:4D-7(k), D-7.1	$9.3 million (estimate)
New York	N.Y. Soc. Serv. Law §§ 366(4)(h), 367-a(2)(b), 104-b	$4.5 million
North Dakota	N.D. Cent. Code § 50-24.1-02.1.	$608,234 (CY 2005 to present)

State	Citation To State Statute	Annual Recoveries
Ohio	Ohio Rev. Code Ann. § 5101.57-.59	$13,775,470.32
Oregon	Or. Rev. Stat. §§ 416.510 to .610	$3.5 million (estimate)
Rhode Island	R.I. Gen. Laws § 40-6-9	$3,104,974
South Carolina	S.C. Code Ann. §§ 43-7-410 to -440	$6.4 million (estimate)
South Dakota	S.D. Codified Laws § 28-6-7.1	$3,758,330 (FY 2004)
Utah	Utah Code Ann. §§ 26-19-1 to -19	$3,218,000 (estimate)
Washington	Wash. Rev. Code §§ 43.20B.050, .060, .070	$ 8,383,807 (FY 2005)
Wisconsin	Wis. Stat. § 49.89	$ 2.6 million (collected by State) 2.7 million (collected by counties) (FY 2005)
Wyoming	Wyo. Stat. Ann. § 41-2-201, -202, -203; 42-4-202, -203	(not available)

Syllabus

NOTE: Where it is feasible, a syllabus (headnote) will be released, as is being done in connection with this case, at the time the opinion is issued. The syllabus constitutes no part of the opinion of the Court but has been prepared by the Reporter of Decisions for the convenience of the reader. See *United States* v. *Detroit Timber & Lumber Co.*, 200 U. S. 321, 337.

SUPREME COURT OF THE UNITED STATES

Syllabus

ARKANSAS DEPARTMENT OF HEALTH AND HUMAN SERVICES ET AL. *v.* AHLBORN

CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

No. 04–1506. Argued February 27, 2006—Decided May 1, 2006

Federal Medicaid law requires participating States to "ascertain the legal liability of third parties . . . to pay for [an individual benefits recipient's] care and services available under the [State's] plan," 42 U. S. C. §1396a(a)(25)(A); to "seek reimbursement for [medical] assistance to the extent of such legal liability," 1396a(a)(25)(B); to enact "laws under which, to the extent that payment has been made . . . for medical assistance for health care items or services furnished to an individual, the State is considered to have acquired the rights of such individual to payment by any other party for such health care items or services," §1396a(a)(25)(H); to "provide that, as a condition of [Medicaid] eligibility . . . , the individual is required . . . (A) to assign the State any rights . . . to payment for medical care from any third party; . . . (B) to cooperate with the State . . . in obtaining [such] payments . . . and . . . (C) . . . in identifying, and providing information to assist the State in pursuing, any third party who may be liable," 1396k(a)(1). Finally, "any amount collected by the State under an assignment made" as described above "shall be retained by the State . . . to reimburse it for [Medicaid] payments made on behalf of" the recipient. §1396k(b). "[T]he remainder of such amount collected shall be paid" to the recipient. *Ibid.* Acting pursuant to its understanding of these provisions, Arkansas passed laws under which, when a state Medicaid recipient obtains a tort settlement following payment of medical costs on her behalf, a lien is automatically imposed on the settlement in an amount equal to Medicaid's costs. When that amount exceeds the portion of the settlement representing medical costs, satisfaction of the State's lien requires payment out of proceeds meant to compensate the recipient for damages distinct

Syllabus

from medical costs, such as pain and suffering, lost wages, and loss of future earnings.

Following respondent Ahlborn's car accident with allegedly negligent third parties, petitioner Arkansas Department of Health Services (ADHS) determined that Ahlborn was eligible for Medicaid and paid providers $215,645.30 on her behalf. She filed a state-court suit against the alleged tortfeasors seeking damages for past medical costs and for other items including pain and suffering, loss of earnings and working time, and permanent impairment of her future earning ability. The case was settled out of court for $550,000, which was not allocated between categories of damages. ADHS did not participate or ask to participate in the settlement negotiations, and did not seek to reopen the judgment after the case was dismissed, but did intervene in the suit and assert a lien against the settlement proceeds for the full amount it had paid for Ahlborn's care. She filed this action in Federal District Court seeking a declaration that the State's lien violated federal law insofar as its satisfaction would require depletion of compensation for her injuries other than past medical expenses. The parties stipulated, *inter alia*, that the settlement amounted to approximately one-sixth of the reasonable value of Ahlborn's claim and that, if her construction of federal law was correct, ADHS would be entitled to only the portion of the settlement ($35,581.47) that constituted reimbursement for medical payments made. In granting ADHS summary judgment, the court held that under Arkansas law, which it concluded did not conflict with federal law, Ahlborn had assigned ADHS her right to recover the full amount of Medicaid's payments for her benefit. The Eighth Circuit reversed, holding that ADHS was entitled only to that portion of the settlement that represented payments for medical care.

Held: Federal Medicaid law does not authorize ADHS to assert a lien on Ahlborn's settlement in an amount exceeding $35,581.47, and the federal anti-lien provision affirmatively prohibits it from doing so. Arkansas' third-party liability provisions are unenforceable insofar as they compel a different conclusion. Pp. 9–23.

(a) Arkansas' statute finds no support in the federal third-party liability provisions. That ADHS cannot claim more than the portion of Ahlborn's settlement that represents medical expenses is suggested by §1396k(a)(1)(A), which requires that Medicaid recipients, as a condition of eligibility, "assign the State any rights . . . *to payment for medical care* from any third party" (emphasis added), not their rights to payment for, *e.g.*, lost wages. The other statutory language ADHS relies on is not to the contrary, but reinforces the assignment provision's implicit limitation. First, statutory context shows that §1396a(a)(25)(B)'s requirement that States "seek reimbursement for

Syllabus

[medical] assistance *to the extent of such legal liability*" refers to "the legal liability of third parties . . . *to pay for care and services available under the plan*," §1396a(a)(25)(A) (emphases added). Here, because the tortfeasors accepted liability for only one-sixth of Ahlborn's overall damages, and ADHS has stipulated that only $35,581.47 of that sum represents compensation for medical expenses, the relevant "liability" extends no further than that amount. Second, §1396a(a)(25)(H)'s requirement that the State enact laws giving it the right to recover from liable third parties "to the extent [it made] payment . . . for medical assistance for health care items or services furnished to an individual" does not limit the State's recovery only by the amount it paid out on the recipient's behalf, since the rest of the provision makes clear that the State must be assigned "the rights of [the recipient] to payment by any other party *for such health care items or services*." (Emphasis added.) Finally, §1396k(b)'s requirement that, where the State actively pursues recovery from the third party, Medicaid be reimbursed fully from "any amount collected by the State under an assignment" before "the remainder of such amount collected" is remitted to the recipient does not show that the State must be paid in full from any settlement. Rather, because the State's assigned rights extend only to recovery of medical payments, what §1396k(b) requires is that the State be paid first out of any damages for medical care before the recipient can recover any of her own medical costs. Pp. 9–13.

(b) Arkansas' statute squarely conflicts with the federal Medicaid law's anti-lien provision, §1396p(a)(1), which prohibits States from imposing liens "against the property of any individual prior to his death on account of medical assistance paid . . . on his behalf under the State plan." Even if the State's lien is assumed to be consistent with federal law insofar as it encumbers proceeds designated as medical payments, the anti-lien provision precludes attachment or encumbrance of the remainder of the settlement. ADHS' attempt to avoid the anti-lien provision by characterizing the settlement proceeds as not Ahlborn's "property," but as the State's, fails for two reasons. First, because the settlement is not "received from a third party," as required by the state statute, until Ahlborn's chose in action has been reduced to proceeds in her possession, the assertion that any of the proceeds belonged to the State all along lacks merit. Second, the State's argument that Ahlborn lost her property rights in the proceeds the instant she applied for medical assistance is inconsistent with the creation of a statutory lien on those proceeds: ADHS would not need a lien on its own property. Pp. 13–17.

(c) The Court rejects as unpersuasive ADHS' and the United States' arguments that a rule permitting a lien on more than medical

Syllabus

damages ought to apply here either because Ahlborn breached her duty to "cooperate" with ADHS or because there is an inherent danger of manipulation in cases where the parties to a tort case settle without judicial oversight or input from the State. As §1396k(a)(1)(C) demonstrates, the duty to cooperate arises principally, if not exclusively, in proceedings initiated *by the State* to recover from third parties. In any event, the aspersions cast upon Ahlborn are entirely unsupported; all the record reveals is that ADHS neither asked to be nor was involved in the settlement negotiations. Whatever the bounds of the duty to cooperate, there is no evidence that it was breached here. Although more colorable, the alternative argument that a rule of full reimbursement is needed generally to avoid the risk of settlement manipulation also fails. The risk that parties to a tort suit will allocate away the State's interest can be avoided either by obtaining the State's advance agreement to an allocation or, if necessary, by submitting the matter to a court for decision. Pp. 17–19.

(d) Also rejected is ADHS' contention that the Eighth Circuit accorded insufficient weight to two decisions by the Departmental Appeals Board (Board) of the federal Department of Health and Human Services (HHS) rejecting appeals by two States from denial of reimbursement for costs they paid on behalf of Medicaid recipients who had settled tort claims. Although HHS generally has broad regulatory authority in the Medicaid area, the Court declines to treat the Board's reasoning in those cases as controlling because they address a different question from the one posed here, make no mention of the anti-lien provision, and rest on a questionable construction of the federal third-party liability provisions. Pp. 19–23.

397 F. 3d 620, affirmed.

STEVENS, J., delivered the opinion for a unanimous Court.

NOTICE: This opinion is subject to formal revision before publication in the preliminary print of the United States Reports. Readers are requested to notify the Reporter of Decisions, Supreme Court of the United States, Washington, D. C. 20543, of any typographical or other formal errors, in order that corrections may be made before the preliminary print goes to press.

SUPREME COURT OF THE UNITED STATES

No. 04–1506

ARKANSAS DEPARTMENT OF HEALTH AND HUMAN SERVICES, ET AL., PETITIONERS *v.* HEIDI AHLBORN

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

[May 1, 2006]

JUSTICE STEVENS delivered the opinion of the Court.

When a Medicaid recipient in Arkansas obtains a tort settlement following payment of medical costs on her behalf by Medicaid, Arkansas law automatically imposes a lien on the settlement in an amount equal to Medicaid's costs. When that amount exceeds the portion of the settlement that represents medical costs, satisfaction of the State's lien requires payment out of proceeds meant to compensate the recipient for damages distinct from medical costs—like pain and suffering, lost wages, and loss of future earnings. The Court of Appeals for the Eighth Circuit held that this statutory lien contravened federal law and was therefore unenforceable. *Ahlborn* v. *Arkansas Dept. of Human Servs.*, 397 F. 3d 620 (2005). Other courts have upheld similar lien provisions. See, *e.g.*, *Houghton* v. *Dept. of Health*, 2002 UT 101, 57 P. 3d 1067; *Wilson* v. *Washington*, 142 Wash. 2d 40, 10 P. 3d 1061 (2000) (en banc). We granted certiorari to resolve the conflict, 545 U. S. ___ (2005), and now affirm.

I

On January 2, 1996, respondent Heidi Ahlborn, then a

19-year-old college student and aspiring teacher, suffered severe and permanent injuries as a result of a car accident. She was left brain damaged, unable to complete her college education, and incapable of pursuing her chosen career. Although she possessed a claim of uncertain value against the alleged tortfeasors who caused her injuries, Ahlborn's liquid assets were insufficient to pay for her medical care. Petitioner Arkansas Department of Health Services (ADHS) accordingly determined that she was eligible for medical assistance and paid providers $215,645.30 on her behalf under the State's Medicaid plan.

ADHS required Ahlborn to complete a questionnaire about her accident, and sent her attorney periodic letters advising him about Medicaid outlays. These letters noted that, under Arkansas law, ADHS had a claim to reimbursement from "any settlement, judgment, or award" obtained by Ahlborn from "a third party who may be liable for" her injuries, and that no settlement "shall be satisfied without first giving [ADHS] notice and a reasonable opportunity to establish its interest."[1] ADHS has never asserted, however, that Ahlborn has a duty to reimburse it out of any other subsequently acquired assets or earnings.

On April 11, 1997, Ahlborn filed suit against two alleged tortfeasors in Arkansas state court seeking compensation for the injuries she sustained in the January 1996 car accident. She claimed damages not only for past medical costs, but also for permanent physical injury; future medical expenses; past and future pain, suffering, and mental anguish; past loss of earnings and working time; and permanent impairment of the ability to earn in the future.

ADHS was neither named as a party nor formally notified of the suit. Ahlborn's counsel did, however, keep ADHS informed of details concerning insurance coverage

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[1] Affidavit of Wayne E. Olive, Exhs. 5 and 6 (Mar. 6, 2003).

as they became known during the litigation.

In February 1998, ADHS intervened in Ahlborn's lawsuit to assert a lien on the proceeds of any third-party recovery Ahlborn might obtain. In October 1998, ADHS asked Ahlborn's counsel to notify the agency if there was a hearing in the case. No hearing apparently occurred, and the case was settled out of court sometime in 2002 for a total of $550,000. The parties did not allocate the settlement between categories of damages. ADHS did not participate or ask to participate in settlement negotiations. Nor did it seek to reopen the judgment after the case had been dismissed. ADHS did, however, assert a lien against the settlement proceeds in the amount of $215,645.30—the total cost of payments made by ADHS for Ahlborn's care.

On September 30, 2002, Ahlborn filed this action in the United States District Court for the Eastern District of Arkansas seeking a declaration that the lien violated the federal Medicaid laws insofar as its satisfaction would require depletion of compensation for injuries other than past medical expenses. To facilitate the District Court's resolution of the legal questions presented, the parties stipulated that Ahlborn's entire claim was reasonably valued at $3,040,708.18; that the settlement amounted to approximately one-sixth of that sum; and that, if Ahlborn's construction of federal law was correct, ADHS would be entitled to only the portion of the settlement ($35,581.47) that constituted reimbursement for medical payments made. See App. 17–20.

Ruling on cross-motions for summary judgment, the District Court held that under Arkansas law, which it concluded did not conflict with federal law, Ahlborn had assigned to ADHS her right to any recovery from the third-party tortfeasors to the full extent of Medicaid's payments for her benefit. Accordingly, ADHS was entitled to a lien in the amount of $215,645.30.

The Eighth Circuit reversed. It held that ADHS was entitled only to that portion of the judgment that represented payments for medical care. For the reasons that follow, we affirm.

II

The crux of the parties' dispute lies in their competing constructions of the federal Medicaid laws. The Medicaid program, which provides joint federal and state funding of medical care for individuals who cannot afford to pay their own medical costs, was launched in 1965 with the enactment of Title XIX of the Social Security Act (SSA), as added 79 Stat. 343, 42 U. S. C. §1396 *et seq.* (2000 ed. and Supp. III). Its administration is entrusted to the Secretary of Health and Human Services (HHS), who in turn exercises his authority through the Centers for Medicare and Medicaid Services (CMS).[2]

States are not required to participate in Medicaid, but all of them do. The program is a cooperative one; the Federal Government pays between 50% and 83% of the costs the State incurs for patient care,[3] and, in return, the State pays its portion of the costs and complies with certain statutory requirements for making eligibility determinations, collecting and maintaining information, and administering the program. See §1396a.

One such requirement is that the state agency in charge of Medicaid (here, ADHS) "take all reasonable measures to ascertain the legal liability of third parties . . . to pay for care and services available under the plan." §1396a(a)(25)(A) (2000 ed.).[4] The agency's obligation

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[2]Until 2001, CMS was known as the Health Care Financing Administration or HCFA. See 66 Fed. Reg. 35437.

[3]The exact percentage of the federal contribution is calculated pursuant to a formula keyed to each State's per capita income. See 42 U. S. C. §1396d(b).

[4]A "third party" is defined by regulation as "any individual, entity or

extends beyond mere identification, however;

> "in any case where such a legal liability is found to exist after medical assistance has been made available on behalf of the individual and where the amount of reimbursement the State can reasonably expect to recover exceeds the costs of such recovery, the State or local agency will seek reimbursement for such assistance to the extent of such legal liability." §1396a(a)(25)(B).

To facilitate its reimbursement from liable third parties, the State must,

> "to the extent that payment has been made under the State plan for medical assistance in any case where a third party has a legal liability to make payment for such assistance, [have] in effect laws under which, to the extent that payment has been made under the State plan for medical assistance for health care items or services furnished to an individual, the State is considered to have acquired the rights of such individual to payment by any other party for such health care items or services." §1396a(a)(25)(H).

The obligation to enact assignment laws is reiterated in another provision of the SSA, which reads as follows:

> "(a) For the purpose of assisting in the collection of medical support payments and other payments for medical care owed to recipients of medical assistance under the State plan approved under this subchapter, a State plan for medical assistance shall—
>
> "(1) provide that, as a condition of eligibility for medical assistance under the State plan to an indi-

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program that is or may be liable to pay all or part of the expenditures for medical assistance furnished under a State plan." 42 CFR §433.136 (2005).

> vidual who has the legal capacity to execute an assignment for himself, the individual is required—
>
> "(A) to assign the State any rights . . . to support (specified as support for the purpose of medical care by a court or administrative order) and to payment for medical care from any third party;
>
> "(B) to cooperate with the State . . . in obtaining support and payments (described in paragraph (A)) for himself . . . ; and
>
> "(C) to cooperate with the State in identifying, and providing information to assist the State in pursuing, any third party who may be liable to pay for care and services available under the plan . . . ." §1396k(a).

Finally, "any amount collected by the State under an assignment made" as described above "shall be retained by the State as is necessary to reimburse it for medical assistance payments made on behalf of" the Medicaid recipient. §1396k(b). "[T]he remainder of such amount collected shall be paid" to the recipient. *Ibid.*

Acting pursuant to its understanding of these third-party liability provisions, the State of Arkansas passed laws that purport to allow both ADHS and the Medicaid recipient, either independently or together, to recover "the cost of benefits" from third parties. Ark. Code Ann. §§20–77–301 through 20–77–309 (2001). Initially, "[a]s a condition of eligibility" for Medicaid, an applicant "shall automatically assign his or her right to any settlement, judgment, or award which may be obtained against any third party to [ADHS] to the full extent of any amount which may be paid by Medicaid for the benefit of the applicant." §20–77–307(a). Accordingly, "[w]hen medical assistance benefits are provided" to the recipient "because of injury, disease, or disability for which another person is liable," ADHS "shall have a right to recover from the person the

cost of benefits so provided." §20–77–301(a).[5] ADHS' suit "shall" not, however, "be a bar to any action upon the claim or cause of action of the recipient." §20–77–301(b). Indeed, the statute envisions that the recipient will sometimes sue together with ADHS, see §20–77–303, or even alone. If the latter, the assignment described in §20–77–307(a) "shall be considered a statutory lien on any settlement, judgment, or award received . . . from a third party." §20–77–307(c); see also §20–77–302(a) ("When an action or claim is brought by a medical assistance recipient . . . , any settlement, judgment, or award obtained is subject to the division's claim for reimbursement of the benefits provided to the recipient under the medical assistance program").[6]

The State, through this statute, claims an entitlement to more than just that portion of a judgment or settlement that represents payment for medical expenses. It claims a right to recover the entirety of the costs it paid on the Medicaid recipient's behalf. Accordingly, if, for example, a recipient sues alone and settles her entire action against a third-party tortfeasor for $20,000, and ADHS has paid that amount or more to medical providers on her behalf, ADHS gets the whole settlement and the recipient is left with nothing. This is so even when the parties to the settlement allocate damages between medical costs, on the one hand, and other injuries like lost wages, on the other.

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[5]Under the Arkansas statute, ADHS' right to recover medical costs appears to be broader than that of the recipient. When ADHS sues, "no contributory or comparative fault of a recipient shall be attributed to the state, nor shall any restitution awarded to the state be denied or reduced by any amount or percentage of fault attributed to a recipient." §20–77–301(d)(1) (2001).

[6]The Arkansas Supreme Court has held that ADHS has an independent, nonderivative right to recover the cost of benefits from a third-party tortfeasor under §20–77–301 even when the Medicaid recipient also sues for recovery of medical expenses. *See National Bank of Commerce* v. *Quirk*, 323 Ark. 769, 792–794, 918 S. W. 2d 138, 151–152 (1996).

The same rule also would apply, it seems, if the recovery were the result not of a settlement but of a jury verdict. In that case, under the Arkansas statute, ADHS could recover the full $20,000 in the face of a jury allocation of, say, only $10,000 for medical expenses.[7]

That this is what the Arkansas statute requires has been confirmed by the State's Supreme Court. In *Arkansas Dept. of Human Servs.* v. *Ferrel*, 336 Ark. 297, 984 S. W. 2d 807 (1999), the court refused to endorse an equitable, nontextual interpretation of the statute. Rejecting a Medicaid recipient's argument that he ought to retain some of a settlement that was insufficient to cover both his and Medicaid's expenses, the court explained:

> "Given the clear, unambiguous language of the statute, it is apparent that the legislature intended that ADHS's ability to recoup Medicaid payments from third parties or recipients not be restricted by equitable subrogation principles such as the 'made whole' rule stated in [*Franklin* v. *Healthsource of Arkansas*, 328 Ark. 163, 942 S. W. 2d 837 (1997)]. By creating an automatic legal assignment which expressly becomes a statutory lien, [Ark. Code Ann. §20–77–307 (1991)] makes an unequivocal statement that the ADHS's ability to recover Medicaid payments from insurance settlements, if it so chooses, is superior to that of the recipient even when the settlement does not pay all the recipient's medical costs." *Id.*, at 308, 984 S. W. 2d, at 811.

Accordingly, the Arkansas statute, if enforceable against Ahlborn, authorizes imposition of a lien on her settlement proceeds in the amount of $215,645.30. Ahlborn's argu-

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[7] ADHS denies that it would actually demand the full $20,000 in such a case, see Brief for Petitioners 49, n. 13, but points to no provision of the Arkansas statute that would prevent it from doing so.

ment before the District Court, the Eighth Circuit, and this Court has been that Arkansas law goes too far. We agree. Arkansas' statute finds no support in the federal third-party liability provisions, and in fact squarely conflicts with the anti-lien provision of the federal Medicaid laws.

III

We must decide whether ADHS can lay claim to more than the portion of Ahlborn's settlement that represents medical expenses.[8] The text of the federal third-party liability provisions suggests not; it focuses on recovery of payments for medical care. Medicaid recipients must, as a condition of eligibility, "assign the State any rights . . . *to payment for medical care* from any third party," 42 U. S. C. §1396k(a) (1)(A) (emphasis added), not rights to payment for, for example, lost wages. The other statutory language that ADHS relies upon is not to the contrary; indeed, it reinforces the limitation implicit in the assignment provision.

First, ADHS points to §1396a(a)(25)(B)'s requirement that States "seek reimbursement for [medical] assistance *to the extent of such legal liability*" (emphasis added) and suggests that this means that the entirety of a recipient's settlement is fair game. In fact, as is evident from the context of the emphasized language, "such legal liability" refers to "the legal liability of third parties . . . *to pay for care and services available under the plan*." §1396a(a)(25)(A) (emphasis added). Here, the tortfeasor

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[8]The parties here assume, as do we, that a State can fulfill its obligations under the federal third-party liability provisions by requiring an "assignment" of part of, or placing a lien on, the settlement that a Medicaid recipient procures on her own. Cf. §§1396k(a)(B)–(C) (the recipient has a duty to identify liable third parties and to "provid[e] information to *assist the State in pursuing*" those parties (emphasis added)).

has accepted liability for only one-sixth of the recipient's overall damages, and ADHS has stipulated that only $35,581.47 of that sum represents compensation for medical expenses. Under the circumstances, the relevant "liability" extends no further than that amount.[9]

Second, ADHS argues that the language of §1396a(a)(25)(H) favors its view that it can demand full reimbursement of its costs from Ahlborn's settlement. That provision, which echoes the requirement of a mandatory assignment of rights in §1396k(a), says that the State must have in effect laws that, "to the extent that payment has been made under the State plan for medical assistance for health care items or services furnished to an individual," give the State the right to recover from liable third parties. This must mean, says ADHS, that the agency's recovery is limited only by the amount it paid out on the recipient's behalf—and not by the third-party tortfeasor's particular liability for medical expenses. But that reading ignores the rest of the provision, which makes clear that the State must be assigned "the rights of [the recipient] to payment by any other party *for such health care items or services*." §1396a(a)(25)(H) (emphasis added). Again, the statute does not sanction an assignment of rights to payment for anything other than medical expenses—not lost wages, not pain and suffering, not an inheritance

Finally, ADHS points to the provision requiring that, where the State actively pursues recovery from the third party, Medicaid be reimbursed fully from "any amount collected by the State under an assignment" before "the remainder of such amount collected" is remitted to the recipient. §1396k(b). In ADHS' view, this shows that the

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[9]The effect of the stipulation is the same as if a trial judge had found that Ahlborn's damages amounted to $3,040,708.12 (of which $215,645.30 were for medical expenses), but because of her contributory negligence, she could only recover one-sixth of those damages.

State must be paid in full from any settlement. See Brief for Petitioners 13. But, even assuming the provision applies in cases where the State does not actively participate in the litigation, ADHS' conclusion rests on a false premise: The "amount recovered . . . under an assignment" is not, as ADHS assumes, the entire settlement; as explained above, under the federal statute the State's assigned rights extend only to recovery of payments for medical care. Accordingly, what §1396k(b) requires is that the State be paid first out of any damages representing payments for medical care before the recipient can recover any of her own costs for medical care.[10]

At the very least, then, the federal third-party liability provisions *require* an assignment of no more than the right to recover that portion of a settlement that represents payments for medical care.[11] They did not mandate

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[10] Implicit in ADHS' interpretation of this provision is the assumption that there can be no "remainder" to remit to the Medicaid recipient if all the State has been assigned is the right to damages for medical expenses. That view in turn seems to rest on an assumption either that Medicaid will have paid all the recipient's medical expenses or that Medicaid's expenses will always exceed the portion of any third-party recovery earmarked for medical expenses. Neither assumption holds up. First, as both the Solicitor General and CMS acknowledge, the recipient often will have paid medical expenses out of her own pocket. See Brief for United States as *Amicus Curiae* 12 (under §1396k(b), "the beneficiary retains the right to payment for any additional medical expenses personally incurred either before or subsequent to Medicaid eligibility and for other damages"); CMS, State Medicaid Manual §3907 (last modified Sept. 16, 2005) (envisioning that "medical insurance payments," for example, will be remitted to the recipient if possible). Second, even if Medicaid's outlays often exceed the portion of the recovery earmarked for medical expenses in tort cases, the third-party liability provisions were not drafted exclusively with tort settlements in mind. In the case of health insurance, for example, the funds available under the policy may be enough to cover both Medicaid's costs and the recipient's own medical expenses.

[11] ADHS concedes that, had a jury or judge allocated a sum for medical payments out of a larger award in this case, the agency would be

the enactment of the Arkansas scheme that we have described.

IV

If there were no other relevant provisions in the federal statute, the State might plausibly argue that federal law supplied a recovery "floor" upon which States were free to build. In fact, though, the federal statute places express limits on the State's powers to pursue recovery of funds it paid on the recipient's behalf. These limitations are contained in 42 U. S. C. §§1396a(a)(18) and 1396p. Section 1396a(a)(18) requires that a State Medicaid plan comply with §1396p, which in turn prohibits States (except in circumstances not relevant here) from placing liens against, or seeking recovery of benefits paid from, a Medicaid recipient:

> "(a) Imposition of lien against property of an individual on account of medical assistance rendered to him under a State plan
>
> "(1) No lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan, except—
>
> "(A) pursuant to the judgment of a court on account of benefits incorrectly paid on behalf of such individual, or
>
> "(B) [in certain circumstances not relevant here]
>
> . . . .

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entitled to reimburse itself only from the portion so allocated. See Brief for Petitioners 49, n. 13; see also Brief for United States as *Amicus Curiae* 22, n. 14 (noting that the Secretary of HHS "ordinarily accepts" a jury allocation of medical damages in satisfaction of the Medicaid debt, even where smaller than the amount of Medicaid's expenses). Given the stipulation between ADHS and Ahlborn, there is no textual basis for treating the settlement here differently from a judge-allocated settlement or even a jury award: all such awards typically establish a third party's "liability" for both "payment for medical care" and other heads of damages.

"(b) Adjustment or recovery of medical assistance correctly paid under a State plan

"(1) No adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan may be made, except [in circumstances not relevant here]." §1396p.

Read literally and in isolation, the anti-lien prohibition contained in §1396p(a) would appear to ban even a lien on that portion of the settlement proceeds that represents payments for medical care.[12] Ahlborn does not ask us to go so far, though; she assumes that the State's lien is consistent with federal law insofar as it encumbers proceeds designated as payments for medical care. Her argument, rather, is that the anti-lien provision precludes attachment or encumbrance of the remainder of the settlement.

We agree. There is no question that the State can require an assignment of the right, or chose in action, to receive payments for medical care. So much is expressly provided for by §§1396a(a)(25) and 1396k(a). And we assume, as do the parties, that the State can also demand as a condition of Medicaid eligibility that the recipient "assign" in advance any payments that may constitute reimbursement for medical costs. To the extent that the forced assignment is expressly authorized by the terms of §§1396a(a)(25) and 1396k(a), it is an exception to the anti-

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[12] Likewise, subsection (b) would appear to forestall any attempt by the State to recover benefits paid, at least from the "individual." See, *e.g.*, *Martin ex rel. Hoff* v. *Rochester*, 642 N. W. 2d 1, 8, n. 6 (Minn. 2002); *Wallace* v. *Estate of Jackson*, 972 P. 2d 446, 450 (Utah 1998) (Durham, J., dissenting) (reading §1396p to "prohibi[t] not only liens against Medicaid recipients but also any recovery for medical assistance correctly paid"). The parties here, however, neither cite nor discuss the anti-recovery provision of §1396p(b). Accordingly, we leave for another day the question of its impact on the analysis.

lien provision. See *Washington State Dept. of Social and Health Servs.* v. *Guardianship Estate of Keffeler*, 537 U. S. 371, 383–385, and n. 7 (2003). But that does not mean that the State can force an assignment of, or place a lien on, any other portion of Ahlborn's property. As explained above, the exception carved out by §§1396a(a)(25) and 1396k(a) is limited to payments for medical care. Beyond that, the anti-lien provision applies.

ADHS tries to avoid the anti-lien provision by characterizing the settlement proceeds as not Ahlborn's "property."[13] Its argument appears to be that the automatic assignment effected by the Arkansas statute rendered the proceeds the property of the State.[14] See Brief for Petitioners 31 ("[U]nder Arkansas law, the lien does not attach to the recipient's 'property' because it attaches only to those proceeds already assigned to the Department as a condition of Medicaid eligibility"). That argument fails for two reasons. First, ADHS insists that Ahlborn at all times until judgment retained her entire chose in action—a right that included her claim for medical damages. The statutory lien, then, cannot have attached until the proceeds materialized. That much is clear from the text of the Arkansas statute, which says that the "assignment shall be considered a statutory lien on any settlement . . . *received by the recipient from a third party*." Ark. Code Ann. §20–77–307(c) (2001) (emphasis added). The settle-

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[13] "Property" is defined by regulation as "the homestead and all other personal and real property in which the recipient has a legal interest." 42 CFR §433.36(b) (2005).

[14] The United States as *amicus curiae* makes the different argument that the proceeds never became Ahlborn's "property" because "to the extent the third party's payment passes through the recipient's hands en route to the State, it comes with the State's lien already attached." Brief as *Amicus Curiae* 18. Even if that reading were consistent with the Arkansas statute (and it is not, see *infra*, at 16), the United States' characterization of the "assignment" simply reinforces Ahlborn's point: This is a lien that attaches *to the property of the recipient*.

ment is not "received" until the chose in action has been reduced to proceeds in Ahlborn's possession. Accordingly, the assertion that any of the proceeds belonged to the State all along lacks merit.

Second, the State's argument that Ahlborn lost her property rights in the proceeds the instant she applied for medical assistance is inconsistent with the creation of a statutory lien on those proceeds. Why, after all, would ADHS need a lien on its own property? A lien typically is imposed on the property of *another* for payment of a debt owed by that other. See Black's Law Dictionary 922 (6th ed. 1990). Nothing in the Arkansas statute defines the term otherwise.

That the lien is also called an "assignment" does not alter the analysis. The terms that Arkansas employs to describe the mechanism by which it lays claim to the settlement proceeds do not, by themselves, tell us whether the statute violates the anti-lien provision. See *United States* v. *Craft*, 535 U. S. 274, 279 (2002); *Drye* v. *United States*, 528 U. S. 49, 58–61 (1999). Although denominated an "assignment," the effect of the statute here was not to divest Ahlborn of all her property interest; instead, Ahlborn retained the right to sue for medical care payments, and the State asserted a right to the fruits of that suit once they materialized. In effect, and as at least some of the statutory language recognizes, Arkansas has imposed a lien on Ahlborn's property.[15] Since none of the federal

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[15] Because ADHS insists that "Arkansas law did *not* require Ahlborn to assign her claim or her right to sue," Brief for Petitioners 33 (emphasis in original), we need not reach the question whether a State may force a recipient to assign a chose in action to receive as much of the settlement as is necessary to pay Medicaid's costs. The Eighth Circuit thought this would be impermissible because the State cannot "circumvent the restrictions of the federal anti-lien statute simply by requiring an applicant for Medicaid benefits to assign property rights to the State before the applicant liquidates the property to a sum certain." App. to Pet. for Cert. 6. Indeed, ADHS acknowledges that Arkansas cannot, for

third-party liability provisions excepts that lien from operation of the anti-lien provision, its imposition violates federal law.

V

ADHS and its *amici* urge, however, that even if a lien on more than medical damages would violate federal law in some cases, a rule permitting such a lien ought to apply here either because Ahlborn breached her duty to "cooperate" with ADHS or because there is an inherent danger of manipulation in cases where the parties to a tort case settle without judicial oversight or input from the State. Neither argument is persuasive.

The United States proposes a default rule of full reimbursement whenever the recipient breaches her duty to "cooperate," and asserts that Ahlborn in fact breached that duty.[16] But, even if the Government's allegations of obstruction were supported by the record, its conception of the duty to cooperate strays far beyond the text of the statute and the relevant regulations. The duty to cooperate arises principally, if not exclusively, in proceedings initiated *by the State* to recover from third parties. See 42 U. S. C. §1396k(a)(1)(C) (recipients must "cooperate with

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example, require a Medicaid applicant to assign in advance any right she may have to recover an inheritance or an award in a civil case not related to her injuries or medical care. This arguably is no different; as with assignment of those other choses in action, assignment of the right to compensation for lost wages and other nonmedical damages is nowhere authorized by the federal third-party liability provisions.

[16] See, *e.g.*, Brief for United States as *Amicus Curiae* 14 (alleging that Ahlborn "omitt[ed] or understat[ed] the medical damages claim from her lawsuit and attempt[ed] to horde for herself the third-party liability payments"); *id.*, at 15 ("[H]aving forsaken her federal and state statutory duties of candid and forthcoming cooperation . . . [,] respondent, rather than the taxpayers, must bear the financial consequences of her actions"); *id.*, at 21, 24 (referring to Ahlborn's "backdoor settlement" and "obstruction and attrition," as well as her "calculated evasion of her legal obligations").

the State in identifying . . . and providing information to assist the State in pursuing" third parties). Most of the accompanying federal regulations simply echo this basic duty; all they add is that the recipient must "[p]ay to the agency any support or medical care funds received that are covered by the assignment of rights." 42 CFR §433.147(b)(4) (2005).

In any event, the aspersions the United States casts upon Ahlborn are entirely unsupported; all the record reveals is that ADHS, despite having intervened in the lawsuit and asked to be apprised of any hearings, neither asked to be nor was involved in the settlement negotiations. Whatever the bounds of the duty to cooperate, there is no evidence that it was breached here.

ADHS' and the United States' alternative argument that a rule of full reimbursement is needed generally to avoid the risk of settlement manipulation is more colorable, but ultimately also unpersuasive. The issue is not, of course, squarely presented here; ADHS has stipulated that only $35,581.47 of Ahlborn's settlement proceeds properly are designated as payments for medical costs. Even in the absence of such a post-settlement agreement, though, the risk that parties to a tort suit will allocate away the State's interest can be avoided either by obtaining the State's advance agreement to an allocation or, if necessary, by submitting the matter to a court for decision.[17] For just as there are risks in underestimating the value of readily calculable damages in settlement negotiations, so also is there a countervailing concern that a rule

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[17] As one *amicus* observes, some States have adopted special rules and procedures for allocating tort settlements in circumstances where, for example, private insurers' rights to recovery are at issue. See Brief for Association of Trial Lawyers of America 20–21. Although we express no view on the matter, we leave open the possibility that such rules and procedures might be employed to meet concerns about settlement manipulation.

of absolute priority might preclude settlement in a large number of cases, and be unfair to the recipient in others.[18]

VI

Finally, ADHS contends that the Court of Appeals' decision below accords insufficient weight to two decisions by the Departmental Appeals Board of HHS (Board) rejecting appeals by the States of California and Washington from denial of reimbursement for costs those States paid on behalf of Medicaid recipients who had settled tort claims. See App. to Pet. for Cert. 45–67 (reproducing *In re Washington State Dept. of Social & Health Servs.*, Dec. No. 1561, 1996 WL 157123 (HHS Dept. App. Bd., Feb. 7, 1996)); App. to Pet. for Cert. 68–86 (reproducing *In re California Dept. of Health Servs.*, Dec. No. 1504, 1995 WL 66334 (HHS Dept. App. Bd., Jan. 5, 1995)). Because the opinions in those cases address a different question from the one posed here, make no mention of the anti-lien provision, and, in any event, rest on a questionable construction of the federal third-party liability provisions, we conclude that they do not control our analysis.

Normally, if a State recovers from a third party the cost of Medicaid benefits paid on behalf of a recipient, the Federal Government owes the State no reimbursement, and any funds already paid by the Federal Government must be returned. See 42 CFR §433.140(a)(2) (2005) (federal financial participation "is not available in Medi-

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[18]The point is illustrated by state cases involving the recovery of workers' compensation benefits paid to an employee (or the family of an employee) whose injuries were caused by a third-party tortfeasor. In *Flanigan* v. *Department of Labor and Industry*, 123 Wash. 2d 418, 869 P. 2d 14 (1994), for example, the court concluded that the state agency could not satisfy its lien out of damages the injured worker's spouse recovered as compensation for loss of consortium. The court explained that the department could not "share in damages for which it has provided no compensation" because such a result would be "absurd and fundamentally unjust." *Id.*, at 426, 869 P. 2d, at 17.

caid payments if . . . [t]he agency received reimbursement from a liable third party"); §433.140(c). Washington and California both had adopted schemes according to which the State refrained from claiming full reimbursement from tort settlements and instead took only a portion of each settlement. (In California, the recipient typically could keep at least 50% of her settlement, see App. to Pet. for Cert. 72; in Washington, the proportion varied from case to case, see *id.*, at 48–51.) Each scheme resulted in the State's having to pay a portion of the recipient's medical costs—a portion for which the State sought partial reimbursement from the Federal Government. CMS (then called HCFA) denied this partial reimbursement on the ground that the States had an absolute duty to seek full payment of medical expenses from third-party tortfeasors.

The Board upheld CMS' determinations. In California's appeal, which came first, the Board concluded that the State's duty to seek recovery of benefits "from available third party sources to the fullest extent possible" included demanding full reimbursement from the entire proceeds of a Medicaid recipient's tort settlement. *Id.*, at 76. The Board acknowledged that §1396k(a) "refers to assignment only of 'payment for medical care,'" but thought that "the statutory scheme as a whole contemplates that the actual recovery might be greater and, if it is, that Medicaid should be paid first." *Ibid.* The Board gave two other reasons for siding with CMS: First, the legislative history of the third-party liability evinced a congressional intent that "the Medicaid program . . . be reimbursed from available third party sources to the fullest extent possible," *ibid.*; and, second, California had long been on notice that it would not be reimbursed for any shortfall resulting from failure to fully recoup Medicaid's costs from tort settlements, see *id.*, at 77. The Board also opined that the State could not escape its duty to seek full reimbursement by relying on the Medicaid recipient's efforts in litigating her

claims. See *id.*, at 79–80.

Finally, responding to the State's argument that its scheme gave Medicaid recipients incentives to sue third-party tortfeasors and thus resulted in both greater recovery and lower costs for the State, the Board observed that "a state is free to allow recipients to retain the state's share" of any recovery, so long as it does not compromise the Federal Government's share. *Id.*, at 85.

The Board reached the same conclusion, by the same means, in the Washington case. See *id.*, at 53–64.

Neither of these adjudications compels us to conclude that Arkansas' statutory lien comports with federal law. First, the Board's rulings address a different question from the one presented here. The Board was concerned with the Federal Government's obligation to reimburse States that had, in its view, failed to seek full recovery of Medicaid's costs and had instead relied on recipients to act as private attorneys general. The Board neither discussed nor even so much as cited the federal anti-lien provision.

Second, the Board's acknowledgment that the assignment of rights required by §1396k(a) is limited to payments for medical care only reinforces the clarity of the statutory language. Moreover, its resort to "the statutory scheme as a whole" as justification for muddying that clarity is nowhere explained. Given that the only statutory provisions CMS relied on are §§1396a(a)(25), 1396k(a), and 1396k(b), see *id.*, at 75–76; *id.*, at 54–55, and given the Board's concession that the first two of these limit the State's assignment to payments for medical care, the "statutory scheme" must mean §1396k(b). But that provision does not authorize the State to demand reimbursement from portions of the settlement allocated or allocable to nonmedical damages; instead, it gives the State a priority disbursement from the medical expenses portion alone. See *supra*, at 12. In fact, in its adjudication in the Washington case, the Board conceded as much:

"[CMS] may require a state to assert a collection priority over funds obtained by Medicaid recipients in [third-party liability] suits *even though the distribution methodology set forth in section [1396k(b)] refers only to payments collected pursuant to assignments for medical care.*" App. to Pet. for Cert. 54 (emphasis added). The Board's reasoning therefore is internally inconsistent.

Third, the Board's reliance on legislative history is misplaced. The Board properly observed that Congress, in crafting the Medicaid legislation, intended that Medicaid be a "payer of last resort." S. Rep. No. 99–146, p. 313 (1985). That does not mean, however, that Congress meant to authorize States to seek reimbursement from Medicaid recipients themselves; in fact, with the possible exception of a lien on payments for medical care, the statute expressly prohibits liens against the property of Medicaid beneficiaries. See 42 U. S. C. §1396p(a). We recognize that Congress has delegated "broad regulatory authority to the Secretary [of HHS] in the Medicaid area," *Wisconsin Dept. of Health and Family Servs.* v. *Blumer*, 534 U. S. 473, 496, n. 13 (2002), and that agency adjudications typically warrant deference. Here, however, the Board's reasoning couples internal inconsistency with a conscious disregard for the statutory text. Under these circumstances, we decline to treat the agency's reasoning as controlling.

VII

Federal Medicaid law does not authorize ADHS to assert a lien on Ahlborn's settlement in an amount exceeding $35,581.47, and the federal anti-lien provision affirmatively prohibits it from doing so. Arkansas' third-party liability provisions are unenforceable insofar as they compel a different conclusion. The judgment of the Court of Appeals is affirmed.

It is so ordered.